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ABSTRACT

The report describes the initial design and the preliminary background exploration, subsequent development, and feasibility testing of methods for conducting a continuing National Ambulatory Medical Care Survey (NAMCS). Selected feasibility study findings are presented to illustrate collected data and suggest kinds of information that may be expected when substantive survey results become available on a continuing national basis. NAMCS was authorized to gather and disseminate statistical information about ambulatory health care provided by office-based physicians to the population of the United States. Ambulatory health care is defined as health services rendered individuals under their own cognizance, at a time when they are not in a hospital or other health care institution. Thirteen pages of detailed tables present the survey results regarding annual volume (1967-1972) and rates of patient visits for population groups, medical specialty groups, and geographic areas. Quantitative descriptions of visit characteristics include tabulations of patient's problems, reasons for visit, diagnoses, services, treatment, and subsequent disposition. The 40-page appendix presents the data collection forms for the survey and field tests. (AG)

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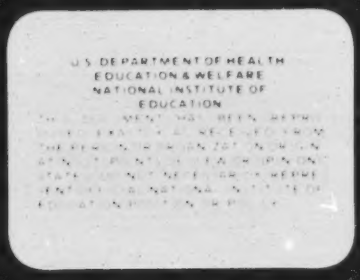

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DATA EVALUATION AND METHODS RESEARCH

Series 2
Number 61

National Ambulatory Medical Care Survey:

Background and Methodology

United States-1967-72

A report on feasibility studies of methods developed for collecting national ambulatory medical care data from practicing office-based physicians in the United States, 1967-72, prepared for the Division of Health Resources Statistics, National Center for Health Statistics, Health Resources Administration, U.S. Department of Health, Education, and Welfare.

DHEW Publication No. (HRA) 74-1335

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

Health Resources Administration
National Center for Health Statistics

Rockville, Md. April 1974

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PREFACE

This report describes the initial design and the preliminary background exploration, subsequent development, and feasibility testing of methods for conducting a continuing National Ambulatory Medical Care Survey (NAMCS). The purpose of NAMCS is to gather and disseminate statistical information on the provision and use of ambulatory health care services in the United States. The work reported here was accomplished from 1967 through 1972, but germinal planning for these methodologic studies stemmed from the report of the Subcommittee on National Morbidity Survey of the U.S. National Committee on Vital and Health Statistics published in 1953.[1] In the 20-year interim, social and technologic changes as well as the efforts of interested organizations, involved individuals, and farsighted leaders contributed to the inauguration of the 1973 NAMCS. Principal contributors during the period of this report were representatives from endorsing medical organizations; the NAMCS Technical Advisory Panel; the contracting organizations—Lea, Inc., and the National Opinion Research Center; the Department of Medical Care and Hospitals of The Johns Hopkins University; and both the National Center for Health Services Research and Development and the National Center for Health Statistics, of the Health Services and Mental Health Administration, U.S. Department of Health, Education, and Welfare.

The principal national sources of statistical information about ambulatory medical care are the practicing, office-based physicians. Without their cooperation this research would not have been possible. Major medical organizations that endorsed the NAMCS project early were as follows: American Medical Association; National Medical Association; American Academy of Dermatology; American Academy of Family Physicians; American Academy of Neurology; American Academy of Orthopaedic Surgeons; American Academy of Pediatrics; American Association of Neurologic Surgeons; American College of Obstetricians and Gynecologists; American College of Physicians; American College of Preventive Medicine; American College of Surgeons; American Osteopathic Association; American Proctologic Society; American Psychiatric Association; American Society of Internal Medicine; American Society of Plastic and Reconstructive Surgeons; American Urologic Association; and Association of American Medical Colleges.

The NAMCS Technical Advisory Panel of individuals with ambulatory health care interests and expertise served as a committee of consultants to the feasibility study from its beginning. Committee members were the following: Theodore R. Ervin; Todd M. Frazier;

and Drs. Barbara Bates, Robert J. Haggerty, Jean L. Harris, Howard H. Hiatt, Robert R. Huntley, Hugh H. Hussey, R. Robert Kalinowski, Chester F. Keefer (deceased), Charles E. Lewis, Kenneth D. Rogers, Paul J. Sanazaro, Patrick B. Storey, and Kerr L. White. Consultants from the Department of Medical Care and Hospitals of the Johns Hopkins University School of Hygiene and Public Health in Baltimore were Drs. James B. Tenney, Kerr L. White, and John W. Williamson.

The National Center for Health Statistics provided sponsorship, supervision, and technical staff support for the entire NAMCS methodologic development project. Siegfried A. Hoermann, Director of the Division of Health Resources Statistics, was Project Administrator and Supervisor; James E. DeLozier has been the Project Officer for the study since 1969; and E. Earl Bryant, of the Office of Statistical Methods, gave consultation and expert assistance for aspects of sampling and survey design.

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NATIONAL AMBULATORY MEDICAL CARE SURVEY:

BACKGROUND AND METHODOLOGY

James B. Tenney, M.D., Dr. P.H.; Kerr L. White, M.D.; and John W. Williamson, M.D.[a]

INTRODUCTION

In April 1973 the National Center for Health Statistics inaugurated the National Ambulatory Medical Care Survey to gather and disseminate statistical information about ambulatory health care provided by office-based physicians to the population of the United States. It is the purpose of the present report to relate the current survey design characteristics and to describe the background and methodology for developing the National Ambulatory Medical Care Survey. Selected feasibility study findings are presented to illustrate collected data and suggest kinds of information that may be expected when substantive survey results become available on a continuing national basis.

AMBULATORY MEDICAL CARE

Definition and Orientation

Ambulatory medical care is the predominant pathway for the provision and use of professional medical services in the United States. It is defined as health services rendered individuals under their own cognizance, at a time when they are not in a hospital or other health care institution. These services, for the largest part, fall under the category of primary care. Primary care is characterized by direct personal contact between patients seeking help for their health problems, and physicians or other health professionals who try to provide it. Secondary or tertiary care applies to services provided ambulatory patients who are referred to specialists or consultant physicians.[2] By definition ambulatory medical care does not include secondary- and tertiary-level care provided hospital inpatients, or lay services given outside formal health care systems.

Ambulatory care takes place in many settings, from patients' homes, neighborhood health centers, and public clinics to hospital outpatient departments and emergency rooms. However, the largest volume of ambulatory care in this country is provided at the doctor's office.[3] It is there that people go when sick, in distress, or out of sorts, and it is there physicians attend them. Approximately 7 of every 10 Americans consult a physician 1 time or more annually, and 7 of every 10 physicians engaged in patient-care

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activities do so principally in office-based practice.[4,5] According to unpublished data from the 1972 National Health Interview Survey, excluding telephone calls, 80 percent of all physician visits take place in the doctor's office; 13 percent at hospital clinics and emergency rooms; and 7 percent at homes, on jobs, or elsewhere.

NEEDS AND USES FOR INFORMATION

Important needs for and uses of statistical data on the volume and characteristics of health care provided in physicians' offices are manifest. Yet the apparent importance of population use and professional practice of ambulatory medical care is not reflected in currently available knowledge. Five broad areas for application are particularly prominent:

1. *National statistics*—The summary accounting of events affecting the Nation's governmental as well as public interest—should have continuing data input for surveillance to reflect the ambulatory care component of the Nation's health services systems. Specifically, the information given should be useful in comparing the use of ambulatory services among different groups of the population over time and in assessing the kind and magnitude of effects associated with changes that occur in health care systems.

2. *Professional education*—The systematic preparation of physicians and other health personnel to meet the health care requirements of the public—needs regular reliable data on the health problems of ambulatory and institutionalized patients and on the professional care they receive. The information would be useful in developing educational priorities and in planning desirable curriculum changes in medical and other health care schools. This would insure that graduates are prepared for the tasks they are called to perform or the medical problems they will be encountering.

3. *Health policy formulation*—The selection, at all levels of care, of alternative directions for administration, management, and implementation in personal health services systems—needs relevant data about ambulatory and institutional services to evaluate sound choices and rational decisions. The information would be useful in assessing alternative plans for modifying health services organizations and delivery systems.

4. *Medical practice management*—The administration and implementation of decisions affecting the planning and conduct of ordinary office practice and patient care—needs regional and national data reflecting contemporary trends in use of services and treatment of patients. The information would be useful in assuring the maintenance of standards and in comparing the effects of alternative procedural patterns and manpower organizational distributions.

5. *Quality assurance*—The systematic effort to assess and improve the effectiveness and efficiency of medical care—needs ambulatory care data to develop baselines for implementing programs of professional standards review. The information would be particularly useful in establishing priorities for research and development of quality assessment standards, instruments, guidelines, and methods.

THE NATIONAL CENTER FOR HEALTH STATISTICS PROGRAM

Authority and Purpose

The National Center for Health Statistics (NCHS) is the principal Federal agency with comprehensive responsibility for compilation, analysis, and dissemination of health statistics; and it serves as a recognized focal point for national leadership in developing coordinated data collection systems to meet public and private needs. Established in 1960 by authorization under both the Public Health Service and National Health Survey Acts, the Center is a separate organizational part of the Health Resources Administration in the U.S. Department of Health, Education, and Welfare. Its major mission is "... to develop and maintain systems capable of providing reliable general purpose, national, descriptive health statistics on a continuing basis, and to publish these statistics for the use of the health and related professions and

industries, both public and private."[5] Accordingly, NCHS is fundamentally concerned with the need for, and has a clear mandate to develop and provide national statistics regarding, ambulatory medical care in the United States.

Current Survey Operations

The Center operates a number of national statistical data collection systems: the national vital statistics of births, deaths, fetal deaths, marriages, and divorces; surveys based on samples of the birth and death records; a continuing nationwide survey of households by interviews; a series of national surveys based on physical examinations of population samples; periodic surveys of nursing homes, hospitals, and other health care facilities and their patients or residents; a continuous national sampling of short-stay hospital records; and surveys of various categories of health manpower based on license renewals, reports from establishments, or other sources. Results are published in several series of statistical reports and are also provided in reference to specific special requests for statistical data or technical assistance.[6] A constant program is maintained to improve these systems and to develop new ones in response to changing needs and demands.

NATIONAL AMBULATORY MEDICAL CARE SURVEY

The National Ambulatory Medical Care Survey (NAMCS) is the contemporary data collection system constituting the outcome of NCHS' concern with developing objective and reliable quantitative information to measure and describe ambulatory health care services for the U.S. population.[7] The initial (1973) NAMCS design is presented here. The features are endorsed by major organizations within the medical profession listed in the preface and are the result of decisions based on experience from the background investigation and methodologic development described in subsequent sections of the report.

PURPOSE AND SCOPE

The purpose of the NAMCS is to meet needs and demands for statistical information about the provision and use of ambulatory medical care services in the United States. Initially, the target population consists of all office visits within the coterminous United States made by ambulatory patients to physicians who are principally engaged in office-based practice but not in the specialties of anesthesiology, pathology, and radiology or in Government service. Telephone contacts and nonoffice visits are excluded. When resources permit feasible survey methods to be developed, the target population will also include visits to other locations and professionals, thus encompassing the remaining fraction of ambulatory medical care initially not within its scope. Complex sampling and reporting problems must be resolved to produce reliable statistical information from hospital outpatient departments and emergency rooms, a most important component of this remainder.

SAMPLE DESIGN

The only objective and reliable sources of data about physicians' services rendered to ambulatory patients during office visits are the physicians themselves and members of their office staffs. The survey population for the NAMCS' multistage probability sample, therefore, includes all physicians in office-based practice responsible for ambulatory patient care, excluding those in anesthesiology, pathology, and radiology or in Government service. The sampling frame is a list of licensed physicians in office-based practice compiled from files that are classified and maintained by the American Medical Association (AMA) and the American Osteopathic Association (AOA). These files are continuously updated by the AMA and AOA, making them as current and correct as possible at the time of sample selection.

The first-stage sample was designed and selected by the National Opinion Research Center (NORC), a nonprofit research organization affiliated with the University of Chicago, which contracted to carry out all phases of NAMCS

field work. A modified probability-proportional-to-size procedure using separate sampling frames for standard metropolitan statistical areas (SMSA's) and for nonmetropolitan counties was employed. After sorting and stratifying by size, region, and demographic characteristics, each frame was divided into sequential zones of 1 million residents, and a random number was drawn to determine which primary sampling unit (PSU) came into the sample from each zone. The final first-stage sample contained 87 PSU's, corresponding to individual counties or small groups of contiguous counties across the country.

The second-stage sample was selected from the list of physicians located in sample PSU's ordered by major specialty categories, so that the overall probability for including any individual was the reciprocal of the number of physicians in the frame at the time of selection. A final sample of 1,705 office-based physicians was thus drawn and assigned by random methods to one of the 52 one-week periods in the year for data collection. Samples for subsequent years will exclude with certainty physicians included within the previous 2 years. In subsequent years larger samples may be employed for more precise estimates or more detailed representation of ambulatory medical care information. Reliability will continue to require preserving strict statistical sampling procedures, unsubstituted collection period assignments, and high participation levels among sample physicians.

SURVEY METHODS

Field Procedures

To maximize participation levels and minimize data collection requirements, assuring objective and reliable information as a result, NAMCS field procedures uniformly emphasize and accommodate the individual circumstances of sample physicians. After receiving introductory letters from NCHS and AMA or AOA, sample physicians are telephoned by informed and trained NORC interviewers who explain the survey briefly and arrange personal appointments to relate more detailed instructions. When interviewers visit, they determine sample physicians' eligibility, ascertain their cooperation, deliver survey materials with printed instructions, and assign predetermined Monday-through-Sunday data collection periods. A short interview concerning basic practice characteristics, such as estimated numbers of patients to be expected, is administered. Office staff who will assist with data collection are invited to attend or are offered separate instruction sessions. Sample physicians are informed of support for the NAMCS by their respective specialty societies. State and local medical societies are made aware of the survey through communications from the AMA as well as from interviewers and field staff supervisors.

Before the beginning and again during the week assigned for data collection, interviewers telephone sample physicians to answer possible questions and to insure that procedures are going smoothly. At the end of the survey week, participating physicians mail finished survey materials to interviewers who edit the forms for completeness before transmitting them for central data processing. Problems at this stage are resolved by interviewer telephone calls to sample physicians; if there are no problems, field procedures are complete with respect to the sample physicians' participation in the NAMCS. Missing information is generally obtained from the patient's medical record by the physician's staff or provided from memory by the physician.

Data Collection

The actual data collection for the NAMCS is carried out by participating physicians, aided by their office assistants when possible. They are requested to complete data collection forms concerning ambulatory patient visits taking place during assigned 1-week periods in their office practices. Based on their own estimates of the numbers of patients expected to visit during the survey period, physicians are assigned to use an "every-patient" or a "patient-sampling" procedure. All procedures are designed so that encounter forms for approximately 10 patient visits be completed each day. Physicians expecting 10 or fewer visits daily record data for all of them, while those expecting more than 10 visits

record data after every second, or third, or fifth visit, observing the same predetermined sampling interval continuously. These procedures minimize the workload of data collection and maintain equal reporting levels among sample physicians regardless of the size of their practices. Each form requires 1-2 minutes to complete, so that approximately 15 minutes are required on days when ambulatory patients are attended in their offices.

Two data collection forms are employed by the participating physicians: the Patient Log and the Patient Record. The Patient Log is a sequential list of patients visiting throughout the survey week that serves to indicate at which visits data should be recorded. The Patient Record is an encounter form which requires 12 items of data about a visit: date and duration of the visit; patient's birthdate, sex, color, and principal problem; physician's estimate of the seriousness of the problem, and whether the patient has been seen for it before; major categorical reasons for the visit; diagnoses; treatment or services; and disposition. Together these items constitute a brief but informative general account of an ambulatory patient visit. The Patient Log and the Patient Record are separate, or attached only by perforation so that sample physicians can keep the Log and mail the Patient Record back to the interviewer after completion, without any indication of patient names to protect confidentiality. Copies of the various Patient Logs and Patient Records are shown in appendix I.

DATA PROCESSING AND RESULTS

Edited NAMCS Patient Records and physician interview information are mailed by the interviewers to NORC for further editing, subsequent coding, and entry on magnetic tapes. Any remaining information identifying individual ambulatory patients is positively deleted. All information that would permit identification of a physician, a practice, or an establishment is held in strict confidence for use only by persons engaged in and for the purposes of the survey, secure from disclosure or release to other persons or use for other purposes.

Initial NAMCS results in the form of summary statistical tabulations of national and regional estimates for numbers of visits, percent distribution, and population rates of use are published as soon as each annual cycle of the continuing NAMCS is complete. More detailed tabulations of visit characteristics by major physician specialties, patient groups, diagnostic categories, treatment provided, and disposition arranged will follow. Cross-tabulations of less common visit characteristics will be published when sufficient data about them are available to meet practical standards of precision. In addition, research findings on the reliability and validity of NAMCS methods, the means to improve and extend them, and on statistics related to specific questions from States or professional specialty groups are under development.

BACKGROUND AND METHODOLOGY

In 1967 the National Center for Health Statistics began planning the project from which the current NAMCS design and methods ultimately developed. NCHS staff members entered into discussions with consultants, practicing physicians, statisticians, and potential contractors to identify ambulatory care data collection problems and prospective approaches to solutions. Contract proposals were solicited for a "pilot study on a survey of physician's records" to develop methods for expanding ". . . the health records program to include samples from records of private physicians." The request was intended to elicit as many proposals and ideas as possible since the prospect appeared more difficult than any the Center had attempted previously, and a heuristic problem-solving approach seemed indicated. After numerous inquiries, half a dozen proposals were finally submitted; the one by Lea, Inc., of Ambler, Pennsylvania, was selected as most likely to succeed on the basis of that company's prior experience and existing resources for surveys involving collection of data from ambulatory medical practice. A technical

advisory group of individuals with nationally recognized interest or experience was named. Initial discussions established a tentative protocol that called for periodic meetings of a working group comprised of the Director of the NCHS Division of Health Resources Statistics, the Project Officer and staff, the contractor's representatives, and a consultant group from The Johns Hopkins University in Baltimore. After several working group meetings and preliminary exploratory investigations, the purpose of the project became clear: a methodologic study was needed to determine the feasibility of collecting ambulatory care data from office-based physicians on an ongoing national survey basis. It would require developing alternative instruments and procedures for data collection, testing them by application among samples of physicians, and evaluating the results according to criteria for feasibility. The NAMCS methodologic study design subsequently evolved in three stages: first, a stage of exploratory studies followed by two stages of feasibility studies, Field Test: Phase I and Field Test: Phase II, each with specific objectives related to the project's purpose.

EXPLORATORY STUDIES

Objectives of the exploratory stage were to define operationally the boundaries and components of the ambulatory care data problem for research and to formulate alternative methods and procedures for subsequent testing and evaluation. The international literature was reviewed, a sample of practicing physicians was interviewed, and individuals with identified interests or experience in the subject were consulted.

Literature Summary

Published accounts of ambulatory care studies, particularly those involving data collection from office-based physicians, documented the relative lack of existing information or broad experience with methods of population-based medical practice surveys outside hospitals or institutions. Since the earliest account in 1842, occasional individuals or small groups of physicians have reported studies of morbidity encountered and services rendered in home and office settings, based principally on analysis of existing records.[8] Reports were reviewed from many countries, including Great Britain, Canada, Australia, Denmark, Germany, Holland, Norway, and the United States.[9] The Royal College of General Practitioners and the General Register Office of the United Kingdom carried out an important survey of 171 physicians from 106 general practices in England and Wales over a 1-year period in 1955-56. It was undertaken after lengthy preliminary explorations of record-keeping techniques following the advent of the National Health Service there.[10] In the United States, relatively extensive studies were restricted to selected groups of practices; notable ones included the surveys reported by Standish et al., by Peterson et al., by the Chronic Illness Project, Inc., and by Kroeger et al.[11-14] Ambulatory care services and utilization among prepaid insurance plan populations had been studied by Weissman and by Densen et al., and from insurance claim form data by Avnet.[15-17] The sole existing source for continuing, professionally defined ambulatory care statistics identified in this country was *National Disease and Therapeutic Index* by Lea, Inc., a commercial survey conducted principally for pharmaceutical marketing research purposes among a quota-sample panel of private physicians.[18] The literature revealed the need for developing uniform terminology, common units of measurement, widely accepted definitions, and for agreeing on practical classifications of patients' problems and diagnostic conditions encountered in ambulatory practice. Information from all the available accounts was sought to help in formulating initial NAMCS methods and feasibility study design.

Office Records Survey

A direct personal interview survey was conducted by Lea, Inc., among a random sample of physicians in private practice, in accordance with contract provisions to explore possible applications of existing office records as a source of national ambulatory care information. A commercial list of physicians was stratified by medical specialty group and geographic region of the country to provide the sampling frame; 358 interviews were successfully completed among

the 400 physicians who were selected as the sample. Results revealed that whereas nearly all respondents kept records, variations in their form, style, content, completeness, and accessibility were extensive. The use of illegible terms, abbreviations, and symbols precluded their use by anyone but the recording physician in 20 percent of cases, and alphabetic filing systems precluded ready relation to defined time periods in 80 percent. Examination of specimen records, which were obtained from two-thirds of the respondents, substantiated the interview findings. It was concluded that practicing physicians alone could provide a range of information concerning ambulatory patient visits in their offices, provided that confidentiality and anonymity were preserved. Since existing records were not a feasible source for data collection, ad hoc encounter forms of some sort, designed for the purpose, became necessary.

Initial Forms Design

Different styles and versions of modified encounter forms were drafted to facilitate the collection of ambulatory patient visit data by physicians. Basic precepts were to minimize workload or practice interference due to record-keeping and to maximize usefulness of the data to be gathered. Form designs were revised repeatedly after consultation with survey research specialists and again after pretesting them among 22 selected physicians practicing in a large metropolitan area. Interviews following their pretest experience suggested that physicians preferred shorter (i.e., 2 days quarterly) instead of longer (i.e., 1 week or 1 month) data collection periods, as well as shorter instead of longer data collection forms as an initial approach to field testing. Most of these exploratory study results were incorporated in the design of subsequent stages of feasibility studies for the NAMCS project.

FEASIBILITY STUDIES: FIELD TEST: PHASE I, 1968-69

Purpose and Design

The purpose of the first phase of feasibility study field testing was to evaluate ambulatory patient visit data collection by a national sample of physicians, using two different data collection forms and three different methods to enlist their participation. The objective was to determine whether any combination of the forms and methods was more feasible as to the proportions of sample physicians agreeing to participate in a national ambulatory medical care survey and later satisfactorily completing data collection forms as requested.

The two forms employed to determine the quantity of data that was feasible for physicians to collect are shown in appendix III. The longer form required about 3 minutes per patient visit to complete, and the shorter one about 1 minute. Both forms requested entries for the patients' purpose or problem, diagnosis, age, race, sex, marital status, and prior visit status, as well as the location and duration of contact, diagnostic procedure, treatment, and disposition. In addition, the longer form requested entries for the patient's socioeconomic, health, and referral status; the physician's estimate of the seriousness of the problem; and more specific diagnostic test details. If physicians wished to retain completed records, the forms were designed so that contact-sensitive code sheets beneath each one could be detached and returned alone.

The three methods of enlisting sample physicians to participate in the survey which were evaluated for feasibility in the Phase I field test were (1) telephone contact by a physician in residency training, (2) telephone contact by a lay interviewer, and (3) personal visit contact by a lay interviewer. Since each approach was employed to enlist physicians for data collection using the long form and the short form, there were six different form-approach combinations for comparison.

The sampling frame was constructed from a commercially maintained list to represent the survey population of all non-Federal, patient care-oriented physicians in office-based practice in the continental United States, excluding specialists in anesthesiology, pathology, and radiology. It was stratified by physician's age group, medical specialty group, and geographic region; and a systematic sample was selected containing 899 doctors of medicine or osteopathy. Each physician was randomly assigned to

one of the six form-approach combinations for the data collection field test.

First, introductory letters were sent to all sample physicians from the Director of the NCHS, which briefly explained the purpose of the study and advised them of the forthcoming call by a representative of the Center. Then efforts were made to contact each physician according to the assigned procedures and to enlist participation of those who were ascertained to be within the predefined scope of the study. Eligible physicians were defined as those who provided care for any ambulatory patients in their practice. Home, office, hospital clinic, or emergency room visits and telephone contacts were included to establish feasibility. They were asked to participate for an assigned 2-day period of data collection, which would recur quarterly for a year. An enlistment interview to elicit practice characteristics, provide instructions, and answer questions was held beforehand, and survey materials with printed instructions were supplied. Finally, after completing data collection forms concerning ambulatory patient visits, participating sample physicians returned them by mail to a central location for tabulation and described their experience at a postsurvey evaluation interview conducted by telephone.

Survey Results

Results of the feasibility study's first phase of field testing are shown in table 1. Of 899 physicians in the total sample at the time it was drawn, 679 (76 percent) were still eligible and available at the time the field test was conducted; they constituted the effective or target sample that was actually approached and asked to participate. Others could not be located, had left practice by death or retirement, did not provide services for ambulatory patients, were unavailable during the survey period, or they were not requested to participate. The relatively large number of ineligible or unavailable physicians was attributed in part to the 6-month period elapsing between drawing the sample and conducting the field test. Of the effective sample approached, nearly three-fourths (74 percent) were enlisted or agreed to participate, and more than one-half (55 percent) did so by completing and returning data collection forms. Differences between sample proportions using and completing the long form and the proportions using and completing the short form were negligible. The expected difference in response for the two forms was not realized, perhaps because both forms seemed long to respondents using only one of them. The different approaches also appeared to have slight overall effect, although telephone contact by resident physicians was slightly more successful than other methods of enlistment, and personal contact by lay interviewers was marginally more successful for completion.

Item completion, the proportion of returned data collection forms on which data were supplied as requested for each specific item, ranged from 90 to 99 percent for items on the short form, and from 85 to 99 percent for items on the long form. Nonresponse to some items was attributed to their relatively inconspicuous position on the forms; for others it seemed more related to the increased time required to make necessary judgments for reply. Hospital emergency room or clinic visit and telephone contact data were relatively underrecorded.

Interviewing at the time of enlistment provided data about practice characteristics that facilitated interpretation of the field test results. Postsurvey interviewing gathered impressions of the physicians' experience and their suggestions for improving survey methods. Reducing the workload for participating physicians and increasing their awareness of the purposes of the methodologic study were the most frequently mentioned practical suggestions to improve future participation.

Conclusions

Conclusions from Field Test: Phase I of feasibility studies for the NAMCS methodologic project were tentative. Ambulatory medical care data collection instruments and procedures had been designed and tested among a national sample of office-based physicians. The results in terms of sample proportions enlisting for participation in the study and actually completing data collection assignments suggested that a national ambulatory medical care survey using such instruments and procedures was potentially feasible. Revisions and improvements appeared

necessary to assure that continuing national statistical information based on methods for data collection by practicing physicians would also meet required NCHS standards of quality and completeness of response.

FEASIBILITY STUDIES: FIELD TEST: PHASE II, 1970-71

Purpose and Design

The purpose of the second phase of feasibility study field testing was to develop and evaluate ambulatory patient visit data collection methods further. Improvements suggested by Phase I field test experience were incorporated in the design, which was aimed specifically at reducing data collection workload and practice interference, increasing the participants' awareness of the purposes of the survey, and strengthening previously established levels of professional interest and support. A subcontract was arranged for the National Opinion Research Center (NORC) to assist with the design and to conduct all survey field work. The scope of the survey was limited to ambulatory patient visits to physicians in their offices, since other methods would be required for outpatient clinics and telephone contacts. Objectives were to increase the proportions of sample physicians agreeing to participate in the survey and satisfactorily completing assigned data collection procedures.

Two data collection forms again were tested: a "short" one required about 1 minute per visit to complete, and a "mini" one required only seconds per visit. The short form corresponded to the shorter form used in Field Test: Phase I; and the miniform embraced an irreducible minimum of useful data, requesting only the patient's age and sex and the physician's diagnosis and type of treatment. The miniform was used primarily to test whether the size of the form would have any effect on physicians' willingness to participate in the survey. The detachable record and code sheet feature of Phase I forms had not proved useful and was discontinued.

A patient sampling procedure was devised to test this method for reducing the data collection workload of participating physicians. Instead of completing a form for every patient visit, those using the sampling procedure were to record data for only every third patient visit. A complete list of every patient visit was needed to insure that the sequence was observed; it would provide a patient sampling frame and afford the added benefit of relative assurance that the data collection process was complete. The number of missed patient visits would be minimized and become measurable in part by this method. Accordingly, a "log" was devised for use in addition to data collection forms, for listing patients visits in the sequence of their arrival in the office, or in any systematic order that fitted usual office procedures and assured completeness. The additional procedure made it necessary to design the field test so as to assess the effect of the log as well as that of the different forms.

One uniform approach to enlisting sample physicians to participate in the survey was adopted as a result of the Phase I experience. A combined telephone-personal-contact method using lay interviewers was employed. The telephone contact served to determine a sample physician's eligibility and availability and to make an appointment for an interviewer's subsequent personal contact. At that time participation was enlisted, data collection requirements and survey procedures were explained, and an interview concerning practice characteristics was held. Sample physicians were encouraged to assign office assistants, secretaries, receptionists, or nurses to help with data collection as much as possible and to maintain the log of patients visiting.

Five data collection form/procedure combinations were tested in Field Test: Phase II of the feasibility study:

1. Short form, log, no sampling
2. Short form, log, sampling
3. Miniform, log, no sampling
4. Miniform, log, sampling
5. Miniform, no log, no sampling

Appendix IV shows copies of these forms and logs.

Survey participation was again enlisted for a 2-day period that would recur quarterly within a year. Six pairs of consecutive days were identified so that sample physicians could be assigned randomly to one of them; for feasibility study

purposes, however, a preselected second pair could be assigned if a physician were unavailable on the first. The same sample of physicians was contacted within 6 months after the initial data collection assignment period to repeat the process in a second quarter in order to estimate expectable attrition if the same methods became feasible to employ for a continuing national survey.

Perhaps the single most important aspect of Phase II field testing was to develop methods of making the medical profession at large and particularly the sample physicians requested to participate more aware of the purpose and significance of an ambulatory medical care survey. Endorsement was first provided by the AMA, and a letter from its Executive Secretary was sent to all sample physicians before an interviewer's telephone call indicating full organizational and professional support for the request to participate. Nineteen medical and professional specialty societies subsequently endorsed the survey in principle. Their support was indicated in the introductory letter sent to all sample physicians from the Director of NCHS to introduce the survey and describe needs and uses for the information expected to result. (Copies of the AMA and the NCHS introductory letters are given in appendix II.) An informative NCHS press release was used by a number of mass-circulation and medical specialty journals, increasing the possibility that physicians would know of the survey. Just before initial telephone contact, supervisory interviewers also called local medical society executives to inform them about the nature and purpose of the survey and to tell them sample physicians in their vicinity would be asked to participate. All these methods were applied to achieve the increased awareness of the survey considered necessary to attain high enlistment and completion rates among a national sample of office-based physicians.

A multistage, stratified national probability sample was selected from a survey population containing all office-based doctors of medicine practicing in the coterminous United States, excluding anesthesiologists, pathologists, and radiologists. Physicians were defined and classified for survey purposes as they are represented on the AMA master list, from which the final sampling frame was constructed. First the preselected sample of PSU's maintained and staffed by NORC was stratified by geographic region and physician population size, and a subsample of PSU's was selected with probability proportional to the number of physicians practicing in each one. Next the AMA list of physicians in the sample PSU's was stratified by age and specialty group, and individuals were systematically selected with a probability inversely proportional to the number practicing in their PSU to form the total sample of 831 physicians. Finally, each sample physician was randomly allocated to one of the five survey form and procedure combinations, to one of the six pairs of consecutive days for data collection, and to one of the interviewers assigned to work in his PSU.

Contacts with physicians began about 3 weeks before the survey period. Letters from both the NCHS Director and the AMA Executive Director were sent to all sample physicians. Efforts were made to telephone physicians by trained lay interviewers who ascertained their eligibility, i.e., whether they provided services for ambulatory patients from offices where they were primarily responsible for the care of such patients over time. The interviewers tried to arrange personal visits with eligible physicians, to explain survey procedures to them and to any designated office assistant whose help could be expected. Data collection forms and printed survey materials were delivered at that time, and a structured enlistment interview was administered to obtain information about anticipated numbers of ambulatory patient visits and other practice characteristics. Later, just before the first data collection days, interviewers telephoned physicians again to remind them about the survey and answer any questions arising in the meantime. When the data collection period was finished, participating physicians mailed survey materials to interviewers, who edited them for completeness and telephoned the participant for a brief postsurvey evaluation interview to obtain information about his experience. All completed data collection forms and interview returns were mailed to a central location for editing, coding, and data processing for analysis. Appendix IV contains copies of the two interview schedules.

At the second-quarter data collection period 6 months later, the same physicians were reminded by letters, contacted by telephone, and sent survey materials by mail, except in instances where additional instructions or answers

to questions required personal visits. Interviews conducted with participants after the data collection period were abbreviated at this stage.

Data processing was oriented toward analysis of survey enlistment and data collection form completion for feasibility study test purposes. Since analysis of the substantive content of patient visit record forms was secondary, survey participation factors were emphasized in coding and tabulation. Information was amalgamated from the interviewers' control folders regarding contacts with physicians, from the enlistment interviews regarding practice characteristics, from the data collection forms regarding patient visits, and from the postsurvey evaluation interviews regarding the data collection process itself. All was coded, entered, and stored on magnetic tape for subsequent computer tabulation and analysis. Weighting factors corresponding to the reciprocal of their probability of selection in the sample were calculated for each physician and employed for interpreting enlistment and completion rates, which constituted the principal feasibility study results.

Survey Results

Results of the second phase of feasibility study field testing are shown in table 2. Of 831 physicians in the total sample at the time it was selected, 746 (90 percent) were both eligible and available to participate at the time of the survey and constituted the effective or target sample for study. The remainder could not be located after persistent attempts, had died or retired, did not have primary responsibility for ambulatory patient care in their offices, or would not be available during the survey period. Eighty-three percent (621) of the effective sample of physicians enlisted or agreed to participate, and 80 percent (595) actually completed forms and returned them following the first-quarter data collection period. If the same proportions are calculated using the weighting factors to adjust for the probability of selection into the sample, 86 percent enlisted and 83 percent completed assigned data collection procedures. The proportion of sample physicians participating in the Phase II survey calculated with or without weighting factors is substantially greater than the 55-percent completion achieved in the Phase I field test. Higher proportions of miniform users than of short form users participated in the survey. Little difference was observed between proportions enlisting in the survey and proportions actually completing data collection for either form. Similarly, negligible differences were noted between proportions of sample physicians using the work-reducing, patient-sampling procedures and those listing every patient and completing forms for each one. There was also little noticeable effect on response by use of the Patient Log; completion rates were 86 and 85 percent, respectively, for physicians using the miniform with the log and those using the miniform without the log. Differences between completion rates by geographic region, specialty, or age group were not significant.

Results after the *second* quarter of the Phase II field test show that 79 percent of the effective or target sample of 721 physicians agreed to participate, and 73 percent of them actually did so. The difference between the effective sample numbers in the two quarters reflects changes among the sample physicians over the interval that affected their eligibility or availability. Additional members left practice, could not be located, or were no longer directly responsible for ambulatory patient care; a few not available the first quarter were eligible to participate in the second, however. Eighty-six percent of those physicians who actually completed data collection forms in the first quarter also completed forms in the second quarter. An overall attrition of 7 percent between quarters was therefore observed. The decrement was slightly greater among physicians listing and recording data for all patients than for those using work-saving sampling procedures.

The quality of data collection represented by the enlistment and completion rates reached in Field Test: Phase II of the feasibility studies is indicated by the record form item completion, and by the proportion of their ambulatory office patients the sample physicians included during their assigned data collection periods. Item completion on Field Test: Phase II first-quarter record forms ranged from 95 to 98 percent for the four miniform items, and from 83 to 99 percent for the 17 variably applicable short form items; the rates were higher than had been achieved in Field Test: Phase I. Sample physicians completing forms were asked whether

they recalled not recording data concerning any ambulatory patients attended in their offices during their assigned periods; 93 percent were confident all were included, and only 2 percent thought more than two patients might have been missed. The number of patients represented by returned data collection forms was consistently about 85 percent of the number of patients these physicians previously had expected would visit, regardless of the data collection form or procedure used. This difference may be due to ambulatory patient visits in nonoffice locations, such as hospital emergency rooms, outpatient clinics, or patient's homes, which did occur as the physicians recalled at the postsurvey evaluation interview but were excluded from the scope of study.

The majority (73 percent) of the 595 sample physicians participating in the first quarter of the feasibility study's Field Test: Phase II survey collected data concerning ambulatory patient visits during the randomly preselected 2-day period first assigned to them. Alternative periods were assigned to another 15 percent who were initially interviewed after the first preselected period had passed, and to 9 percent more who expected to see no ambulatory patients in the first preselected period. These reasons were sufficient for alternative data collection period assignments for feasibility study purposes; alternative periods would be unnecessary for purposes of a continuing survey using similar methods because physicians could be interviewed early and could record zero visits on nonpractice days.

Postsurvey evaluation interviews after the first quarter of Field Test: Phase II showed that methods designed to increase awareness of the survey and its potential benefits had been effective and warranted. More than half the responding sample physicians indicated that the introductory letters they received beforehand favorably influenced their decision to participate. The proportions were 63 percent for the AMA letter and 56 percent for the NCHS letter; the remainder indicated they were uninfluenced by or did not recall receiving either letter. Half the NCHS letters were sent by certified mail, with no discernible effects on recall or participation. Only a few respondent physicians consulted local medical society officials or discussed survey participation with colleagues. Other favorable factors cited were the worthwhile purpose of the survey and the persuasiveness of the interviewers. Forms, procedures, and survey materials presented no consistent problems for these participants, although a number of mini-form users questioned the usefulness of the small amount of data they collected for potential ambulatory care statistics.

Conclusions

Based on the foregoing results and accrued experience after Field Test: Phase II of the feasibility studies, the maturing methods and procedures developed and tested to date were considered feasible for application when the continuing NAMCS was inaugurated. Extensive and improved levels of participation by practicing office-based physicians, in terms of sample proportions collecting patient visit data under field trial conditions, supported this conclusion. Nevertheless, the critical importance of maintaining high levels of participation also warranted variation and testing of methods and procedures to refine them further under actual continuing survey conditions. Short data collection forms and simple patient sampling procedures were found to be practicable. Advance information about the survey's nature, purpose, and significance appeared to be a prerequisite for success; and support from organized medicine, professional societies, and publications at national and local levels proved to be a practical means of increasing physician response. The completeness and quality of patient visit data collection as estimated in the field trial seemed sufficient to support feasibility study results, but procedural reliability and content validity remain to be established after the NAMCS has commenced.

ILLUSTRATIVE FEASIBILITY STUDY FINDINGS

INTRODUCTION AND METHODS

The purposes of both field phases of the NAMCS feasibility studies described in this report were methodologic, by design. These surveys were conducted to develop and test, and subsequently improve and test, instruments and procedures for ambulatory care data collection by practicing office-based physicians on a continuing national basis. The instruments and procedures that were developed and the results of their feasibility testing have been related in foregoing sections. It is through the application, continuing evaluation, and refinement of such methods that the goal of statistical information reflecting the important but relatively underrepresented ambulatory component of health care services for the population may be realized.

As a byproduct of Field Test: Phase II of the feasibility studies, a volume of data collected from actual ambulatory patient visits to practicing office-based physicians regarding the patients' visits and the services they were provided became available. These data are subject to important limitations by virtue of their byproduct nature and cannot be presented either as a quantitatively precise or statistically accurate representation of the subjects contained within them. Participation by physicians was less than complete and it varied within and between quarters. Five different form-procedure combinations were employed for data collection, and substitution for preassigned recordkeeping periods was permitted for feasibility study purposes. The amount of data collected at ambulatory patient visits concerning different characteristics varied because of the different form lengths and patient sampling procedures that were required. For these reasons as well as the costs that would be incurred, the feasibility study data were not adjusted for nonresponse or weighted to reflect the national population basis for the probability samples of PSU's as well as physicians. The small sample size and volume of data and the lack of uniform content or collection methods also precluded calculating useful estimates of national utilization rates or other office-based ambulatory medical care parameters. Statistical information of the necessary kind and quality still depends on results of the continuing NAMCS.

At the same time, these data have inherent interest for potential users of NAMCS information. Selected summary findings may indicate kinds of information to be expected or suggest useful analyses or tabulations for practical application when continuing survey results may be obtained. The authors therefore undertook a limited exploration of the Field Test: Phase II byproduct data, with permission, cooperation, collaboration, and support from NCHS. Under their direction a group of summer apprenticeship-traineeship medical and dental students, supervised by preceptors, applied standardized computer programs to tabulate and analyze the magnetic-tape-stored data. Additional coding and key punching for patient problem and diagnosis data were accomplished by experienced staff from the Center. The proportional distributions, ranked frequencies, and cross-tabulations that follow are the findings from this analysis. Wherever bias may appear due to aggregation or subdivision of entries, it is a consequence of described data limitations and the authors' judgment and does not necessarily reflect the style or format of subsequent NAMCS results or tabulations.

The data are presented here with only minimal discussion, which represents comments that could accompany similar data from the NAMCS. The reader is CAUTIONED, however, that these data are not to be considered representative of national statistics and should be regarded only as illustrative of tabulations expected in the future from the NAMCS.

DATA SOURCE AND VOLUME

Office-based physicians participating in Field Test: Phase II of the feasibility study and the patient visits from which they collected data for analysis and presentation here are shown in table 3 by number and percent according to specialty groups.

The numbers of physicians shown in the first column of table 3 used short form procedures in the first and/or second quarters of the survey to record patient visit data. Although the short

form procedures provided over four times as many items of data per visit as miniforms and produced the only survey data that were collected about a number of visit characteristics, they constituted only two of the five survey procedures. The number of physicians assigned short form procedures was correspondingly small compared to the overall number of participating physicians. For these reasons, subsequent analyses of data provided by short forms alone did not include characterization by the specialty groups listed in table 3, but were limited to the physicians' type of practice, either specialty or general and family practice. The numbers of physicians in each type of practice may be ascertained by reference to this table.

The percent distribution of participating physicians using all survey procedures, shown in the third column of table 3, was compared with the corresponding distribution calculated from the numbers of all office-based physicians (excluding anesthesiologists, pathologists, and radiologists) in the United States and possessions at the end of December 1971.[19] Differences exceeding approximately 2 percent were found for two specialty groups; 4.4 percent more participating than all office-based physicians were in general surgery, and 8.2 percent fewer were in the "remaining other specialties" category.

The percent distribution of participating physicians is less similar to the percent distribution of patient visits, also shown in table 3, in several respects. Physicians in primary care specialties reported relatively more patient visits and those in secondary/tertiary care specialties reported relatively fewer patient visits than might be expected on the basis of their proportions among the participants. Physicians in general and family practice comprised a quarter of those participating and reported a third of the visits; pediatricians comprised 4.7 percent and reported 8 percent. Psychiatrists and neurologists, who made up 6.8% percent of all participants, reported 3.1 percent of all visits.

AGE AND SEX OF PATIENTS

Tables 4 and 5 show the ambulatory visits to each specialty group of office-based physicians according to the age group and sex of patients visiting, respectively. Table 6 shows the distribution of all visits by both sex and age group of patients visiting. Together these tables provide a quantitative description of two major demographic variables for the entire group of ambulatory care visits, as well as for visits to physicians in major specialty groups providing ambulatory medical care services.

The first row of table 4 displays the percent distribution of all ambulatory patient visits reported during Field Test: Phase II among broad age groups of patients. By comparison, proportionately more visits to physicians in primary care specialties were made by younger patients. A small percentage of visits to pediatricians was made by patients over the age of 14, and a still smaller percentage of visits to general internists was made by patients of 14 years or less. The age distribution of patients visiting physicians in general and family practice resembles that of all patient visits. By contrast, relatively fewer patient visits to secondary/tertiary care physicians were made by the younger patients. The bulk of visits to obstetrician-gynecologists were, of course, by patients in their childbearing years; this is also true for patient visits to psychiatrists-neurologists, for reasons that are less obvious.

The sex of patients visiting physicians in different specialty groups is shown in table 5. The majority of ambulatory patient visits are made by females, but not in pediatric or orthopedic surgery practices. The distributions by sex of visits to physicians in primary and in secondary/tertiary care specialties are similar, although, as expected, females made nearly all visits to obstetrician-gynecologists.

Table 6 shows the overall number and percent distribution of all Field Test: Phase II office visits by patient sex and age group. The majority are made by females, but males predominate slightly at ages 65 years and over. By comparison with a similar distribution constructed for the estimated total U.S. population in 1971, the proportion of office visits by females is 5 percent greater than the proportion of females in the U.S. population.[20] For the youngest age group, the proportions of visits and of the population are similar: but for the age group 5-14 years, the proportion of visits is approximately half their proportion of the total. Visits by women aged 25-44 years make up more than

16 percent of all visits, though women of this age group constitute 12 percent of the entire population. Additional data will afford a closer examination of such characteristics when NAMCS results are available.

PROBLEMS AND DIAGNOSES

The most common patient problems encountered by the office-based physicians using short form procedures are shown in table 7, and the most common diagnoses and the major classes of diagnoses recorded at all ambulatory patient visits during both quarters of Field Test: Phase II are shown in tables 8 and 9.

These three tables represent results of coding using the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States* (ICDA), with its supplementary classification for "Special Conditions and Examination Without Sickness."[21] Individuals experienced in using the classification for coding hospital discharge abstracts and death certificate diagnoses were employed to apply its rules and procedures for entries recorded after the ambulatory patient visits. Entries for the patients' purpose, problem, or chief complaint could not be coded for 2.6 percent of the short form procedure visits, and entries for the most important diagnosis accounting for the visit could not be coded for 8.5 percent of all the visits. In part this was because these items were not completed by the data-collecting physicians and in part because entries that were made could not be assigned to any categories of the classification. The ICDA, which was designed to code and classify well-defined diseases and causes of death, was difficult and unwieldy to apply for many of the relatively ill-defined symptoms, problems, complaints, and clinical impressions that label conditions which ambulatory patients present in office-based medical practice. Following recommendations of the Chicago Conference on Ambulatory Medical Care Records, NCHS has subsequently been participating actively in the development of improved classifications for patients' problems and conditions encountered in ambulatory medical care.[22]

Common patient problems within the diagnostic categories listed in table 7 were reasons for the majority of these ambulatory patient visits. Examinations of essentially well persons and followup care for others were most prominent. Lower on the list but still within the first 15 categories were such nonspecific and well-known conditions as sore throat, nervousness, backache, common cold, and obesity, which bring numbers of patients to visit doctors and require a proportion of the ambulatory health care services they provide. Essential benign hypertension, elsewhere a specific diagnosis, here reflects visits for the purpose of having blood pressure checked. The common reasons patients present for ambulatory care visits are principally classified in broadly defined, nonspecific, and residual ICDA categories.

The diagnostic categories listed in table 8 contain the common diagnoses or disease labels participating office-based physicians assigned to the patients' conditions that they thought accounted for each ambulatory care visit during the survey. Relatively few of the 872 ICDA three-digit categories include a good many of the diagnoses they assigned; none of the remainder contained diagnoses made at more than 1 percent of the visits. Although nonspecific, residual, and combined categories appear on the list, many contain well-defined disease entities such as hypertension, chronic ischemic heart disease, diabetes, obesity, otitis media, acute pharyngitis, bronchitis, hay fever, and acute tonsillitis. Visits for diagnoses under followup care, examination, and prenatal care categories are as prominent in order of frequency as these categories were found to be among the patient problems in table 7. In part, this finding may reflect agreement between physicians' views of patients' purposes or reasons for visiting and of their own professionally defined diagnostic labels for their patients' conditions. The first listed category of unassigned diagnoses in part reflects the measure of uncertainty with which specific diagnoses are often made in office-based practice. Provisional treatment for expected disease and early management of undiagnosed and still-undifferentiated symptoms or symptom complexes in ambulatory patients is commonplace.

Table 9 lists the major ICDA classes of diagnostic categories in the rank order of their frequency as reasons for the ambulatory patient visits included in Field Test: Phase II. Compari-

son of this ranked list with similar ones for hospital discharge diagnoses and for causes of death in the United States facilitates interpretation.[23,24] The supplementary class, "Special conditions and examinations without sickness," leads the ambulatory visit list, followed by "Diseases of the respiratory system" and the class of conditions for which no diagnostic category was assigned. The class containing conditions responsible for the largest number of deaths in this country, "Diseases of the circulatory system," appears fourth on the list for visits. "Neoplasms," second in order as a cause of death and seventh as a cause of hospitalization, is 15th as a cause for ambulatory patient visits here, followed by classes of conditions for which fewer than 1 percent of the visits were made. "Diseases of the digestive system," the second most common cause of hospitalization and fifth of deaths, is 14th in table 9. "Accidents, poisonings, and violence" and "Diseases of the respiratory system" are classes accounting for relatively large proportions of ambulatory visits as well as of hospitalizations and deaths. The differences and similarities observed between ranked classes of diagnostic categories accounting for ambulatory visits, for hospital-treated morbidity, and for mortality suggest the potential utility of such statistical information to provide perspective for establishing priorities and policy for health care services.

SELECTED CHARACTERISTICS OF VISITS

Tables 10-18 show distributions of Field Test: Phase II ambulatory patient visits to office-based physicians in two broad types of practice, according to selected characteristics related to patients visiting, services and treatment provided, dispositions arranged, and durations of visits. Data concerning these characteristics were collected by physicians using the two short form survey procedures, and thus the majority of these analyses and tabulated findings are based on the subsample of visits they reported. Data on treatment provided at visits were also collected by physicians using miniform procedures, and table 16 is consequently based on all visits during the survey.

The color and current marital status of patients visiting are presented in tables 10 and 11. Over 90 percent were white, about 3 percent more than the proportion of white persons in the resident United States population.[25] In part, this is because larger proportions of persons other than white than of white persons may visit less frequently, or attend hospital clinics and emergency rooms instead of physicians' offices, for ambulatory health care services. More than half the patients were married, and about one-third were single.

The findings presented in table 12 show that less than one in five visits were made by patients new to the physician. About 63 percent of patients visiting physicians in specialty practice had previously been seen for the same problem, and about 16 percent for other problems. By contrast, 49 percent of patients visiting physicians in general and family practice had been seen before for the same problem, and about 30 percent for other problems.

The extent to which histories were taken and physical examinations performed at ambulatory patient visits is shown in table 13. Histories were obtained in about 87 percent of visits; these were limited in extent about twice as frequently as they were general. The proportion of visits to physicians in specialty practice at which no history was taken exceeds the comparable proportion in general and family practice.

Examinations followed the same pattern as histories. An examination was performed at 9 of 10 visits, and more than twice as many were limited as were general in nature. Proportions of visits including general examinations were lower, and limited examinations higher, in general and family practice than in specialty practice. Visits at which examinations were not performed at all were more frequent among physicians in specialty than in general and family practice.

Table 14 shows the distribution of ambulatory patient visits according to whether diagnostic tests were ordered, and for what purpose they were intended. Laboratory procedures, X-ray examinations, and other diagnostic procedures were not ordered for any reason at a large majority of visits, and at others physicians did not know or did not record whether tests were ordered or their intent. Visits to physicians in specialty practice included laboratory proce-

dures for screening more commonly than visits to physicians in general and family practice. The proportion of visits at which diagnostic test data were incomplete or unknown may reflect the middle position this item occupied on the data collection form, or uncertainty by physicians as to how to classify the purpose of tests that were ordered or performed.

Diagnostic specimens such as blood, urine, and other samples needed for diagnostic tests were not taken at approximately two-thirds of these ambulatory patient visits, as shown in table 15. At the remainder, specimens were taken less commonly by physicians themselves than by office staff or others, particularly in specialty practice, where they were obtained at 31 percent of visits. The proportions of visits at which specimens were taken are similar to those at which laboratory procedures were ordered, on comparison with percentages shown in table 14.

Table 16 presents findings from all Field Test: Phase II ambulatory patient visits and shows their distribution according to broad types of treatment provided by the office-based physicians. At more than half of the visits drugs of some type were prescribed, administered, dispensed, or advised; drug therapy was provided more commonly in general and family practice than in specialty practice. No treatment was considered needed at 17 percent of the visits, and advice concerning diet, exercise, or habit changes was given at 12 percent. Therapeutic listening or psychotherapy was recorded as a type of treatment employed at almost 8 percent of the visits. This 8 percent may be an underestimate, since it included visits at which the modality was purposefully pursued, but not others at which it may have gone unrecognized as part of the therapeutic exchange between the patient and the physician. Other treatment was provided at one-fourth of the visits; it was proportionally more prominent among visits to physicians in specialty types of practice, as might be expected. In contrast to the findings concerning diagnostic tests and specimens in tables 14 and 15, treatment was unknown or unrecorded at less than 1 percent of visits.

Disposition and followup plans after visits to physicians using short form survey procedures are presented in table 17. Appointments for return visits were specifically arranged following the majority, and less specific directions to return if necessary were given at one-fourth of the visits. Relatively fewer specific appointments and more general arrangements were made after visits to physicians in general and family practice than in specialty practice. No further followup or telephone followup was planned after 9 and 7 percent of these visits, respectively. Patients were referred for admission to hospital after approximately 4 percent of visits, predominantly to remain under the same physician's care there. Patients were referred to another physician after 2 percent of visits, and directed to return to another referring physician or agency after 1 percent. The different proportional distributions observed between visits to physicians in specialty and in general and family practice are expected, as these broad types of practice differ with respect to the patients served, conditions treated, and services provided.

Table 18 shows the volume and distribution of ambulatory patient visits by their duration in minutes spent in face-to-face or other direct contact between patients and physicians. Nearly half the visits were completed within 10 minutes or less, and only a small minority lasted more than 30 minutes. Shorter visits predominated in general and family practice, longer ones in specialty practice.

From the illustrative findings contained in this section of the report, an impression may be gained concerning the ambulatory care data gathered by office-based physicians during Field Test: Phase II of the NAMCS Feasibility Study. The same kinds of data, modified, refined, and multiplied, are expected to be collected during the ongoing NAMCS. Results will make varied and detailed analyses possible, and quantitative statistical information concerning office-based ambulatory health care services provided for the U.S. population will become available.

SUMMARY AND CONCLUSION

In 1973 the National Ambulatory Medical Care Survey was inaugurated by the National Center for Health Statistics to gather data and promulgate statistical information concerning

the provision and use of ambulatory health care services for the population of the United States. A national probability sample of office-based physicians now collects data from ambulatory patient visits during 1-week periods in their practices. Processing and analysis of the results provide national and regional estimates of the annual volume and rates of ambulatory patient visits for population groups, medical specialty groups, and geographic areas. Quantitative descriptions of visit characteristics include tabulations of patient's problems, reasons for visiting, medical diagnoses, services, treatment, and subsequent disposition.

The background and development of methods employed for the NAMCS required exploratory and feasibility studies conducted over a period of 6 years. Literature review and consultation documented needs and potential uses for national ambulatory medical care statistics. Information regarding accepted definitions, uniform terminology, procedural experience, or practical classifications for the problems and conditions encountered in ambulatory care settings was found to be limited. First, data collection forms and procedures were developed and tested by sample physicians in a national field survey, which demonstrated the difficulty of achieving high levels of participation. Refined data collection forms and improved procedures were further tested by a second sample of physicians in an extensive national survey lasting over 2 quarters in 1 year. Results demonstrated the usefulness of professional endorsement, procedural efficiency, and minimal work requirements in achieving physician-participation levels exceeding 80 percent.

As a byproduct of the latter phase of feasibility studies, a volume of ambulatory visit data became available. It was analyzed and presented to illustrate kinds of information NAMCS results will provide. Subject to described limitations of the data, percent distributions of 23,407 ambulatory patient visits to a national probability sample of office-based physicians are shown by categories of patients, specialty groups of physicians, and characteristics of visits. Common patient problems and physician diagnoses are ranked in order of their frequency. These findings may suggest potential applications for NAMCS results, which will supplement existing NCHS programs with information from ambulatory patient visits in office-based practice. The added NAMCS results will assure that a more comprehensive range of statistical information is available concerning the entire spectrum of health care services for the population of the United States.

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Table 1. Number of physicians in sample and percent enlisting in and completing forms for Field Test: Phase I, NAMCS Feasibility Study, by enlistment method and length of form: United States, 1969

Enlistment method and form length	Number of physicians[1]	Percent enlisting	Percent completing
Total, all methods and forms	679	74	55
Total, long forms	351	73	54
Total, short forms	328	75	56
Telephone contact by resident physician			
Total	224	80	54
Long forms	118	78	50
Short forms	106	82	58
Telephone contact by lay interviewer			
Total	241	73	47
Long forms	122	73	50
Short forms	119	74	54
Personal contact by lay interviewer			
Total	214	70	61
Long forms	111	75	65
Short forms	103	64	57

[1] Effective or target sample number is given; it excludes 220 (24 percent) of 899 total sample physicians, who were unavailable or ineligible according to prior survey definitions, and hence were not requested to participate or complete forms.

Table 2. Number of physicians in sample and percent enlisting in and completing forms for Field Test: Phase II, NAMCS Feasibility Study, by data collection form and procedure: United States, 1971

Data collection form and procedure	First quarter			Second quarter		
	Number of physicians[1]	Percent enlisting	Percent completing	Number of physicians[1]	Percent enlisting	Percent completing
Total, all forms and procedures	746	83	80	721	79	73
Total, short form	301	78	74	291	74	67
Total, miniform	445	87	84	430	82	78
Log and sampling procedures						
Total	285	84	78	278	81	73
Short forms	143	82	76	141	79	72
Miniforms	142	86	80	137	83	74
Log, no sampling procedures						
Total	310	81	78	298	74	69
Short forms	158	74	72	150	68	62
Miniforms	152	88	86	148	80	77
No log, no sampling procedure						
Miniforms	151	87	85	145	83	82

[1] Effective or target sample numbers are given; they exclude 85 (10 percent) of 831 total sample physicians the first quarter, and 56 (7 percent) of 777 the second quarter, who were unavailable or ineligible according to prior survey definitions, and hence were not requested to participate or complete forms.

Table 3. Number and percent distribution of 645 office-based physicians participating in Field Test: Phase II, NAMCS Feasibility Study and of 23,407 ambulatory patient visits, by specialty of physicians: United States, 1971

Specialty of physicians	Participating physicians			Patient visits	
	Number of short-form procedures	Number of all study procedures	Percent distribution of all study procedures	Number of all study procedures	Percent distribution of all study procedures
Total, all specialties	246	645	100.0	23,407	100.0
Primary care specialties					
Total	101	283	43.9	12,538	53.6
General and family practice	62	166	25.7	7,932	33.9
General internal medicine	27	87	13.5	2,723	11.6
General pediatrics	12	30	4.7	1,883	8.0
Secondary/tertiary care specialties					
Total	145	362	56.1	10,869	46.4
General surgery	39	92	14.3	2,512	10.7
Obstetrics-gynecology	23	52	8.1	1,873	8.0
Orthopedic surgery	16	38	5.9	1,507	6.4
Other surgical specialties	32	84	13.0	2,421	10.3
Psychiatry-neurology	11	44	6.8	718	3.1
Other medical specialties	19	40	6.2	1,461	6.2
Remaining other specialties	5	12	1.9	377	1.6

Table 4. Number and percent distribution of 23,407 ambulatory patient visits to office-based physicians participating in Field Test: Phase II, NAMCS Feasibility Study, by age of patients and specialty of physicians: United States, 1971

Specialty of physicians	Number of patients	All ages	0-14 years	15-44 years	45-64 years	65 years and over	Not stated
		Percent distribution					
Total, all specialties	23,407	100.0	19.1	43.0	25.7	12.7	1.5
Primary care specialties							
Total	12,538	100.0	26.9	36.6	22.1	12.9	1.5
General and family practice	7,932	100.0	19.2	43.7	22.7	12.7	1.8
General internal medicine	2,723	100.0	2.8	38.1	35.0	22.7	1.3
General pediatrics	1,883	100.0	94.0	4.9	0.5		0.6
Secondary/tertiary care specialties							
Total	10,869	100.0	10.1	50.4	25.5	12.4	1.5
General surgery	2,512	100.0	10.3	45.6	29.9	12.4	1.8
Obstetrics-gynecology	1,873	100.0	0.9	84.7	11.0	1.9	1.6
Orthopedic surgery	1,507	100.0	20.4	42.7	27.3	8.8	0.9
Other surgical specialties	2,421	100.0	15.2	35.1	30.8	17.9	1.0
Psychiatry-neurology	718	100.0	5.3	73.4	17.1	1.9	2.2
Other medical specialties	1,461	100.0	7.1	37.4	27.4	26.7	1.3
Remaining other specialties	377	100.0	1.9	48.5	35.5	9.8	4.2

Table 5. Number and percent distribution of 23,407 ambulatory patient visits to office-based physicians participating in Field Test: Phase II, NAMCS Feasibility Study, by sex of patients and specialty of physicians: United States, 1971

Specialty of physicians	Number of patients	Both sexes	Male	Female	Not stated
		Percent distribution			
Total, all specialties	23,407	100.0	41.6	56.6	1.8
Primary care specialties					
Total	12,538	100.0	43.1	55.1	1.8
General and family practice	7,932	100.0	41.3	56.7	2.0
General internal medicine	2,723	100.0	40.4	58.0	1.7
General pediatrics	1,883	100.0	54.8	44.2	1.0
Secondary/tertiary care specialties					
Total	10,869	100.0	39.9	58.3	1.8
General surgery	2,512	100.0	47.6	50.8	1.6
Obstetrics-gynecology	1,873	100.0	1.7	96.1	2.2
Orthopedic surgery	1,507	100.0	51.6	47.4	1.0
Other surgical specialties	2,421	100.0	47.9	50.7	1.4
Psychiatry-neurology	718	100.0	40.5	57.1	2.4
Other medical specialties	1,461	100.0	43.8	54.5	1.7
Remaining other specialties	377	100.0	65.3	30.0	4.8

Table 6. Number and percent distribution of 23,407 ambulatory patient visits to office-based physicians participating in Field Test: Phase II, NAMCS Feasibility Study, by sex and age of patients: United States, 1971

Age of patients	Both sexes		Male		Female		Not stated	
	Number	Percent distribution	Number	Percent distribution	Number	Percent distribution	Number	Percent distribution
Total, all ages	23,407	100.0	9,749	41.6	13,243	56.6	415	1.8
0-4 years	1,993	8.5	1,044	4.5	930	4.0	19	0.1
5-14 years	2,477	10.6	1,310	5.6	1,148	4.9	19	0.1
15-24 years	3,908	16.7	1,505	6.4	2,376	10.2	27	0.1
25-44 years	6,166	26.3	2,280	9.7	3,839	16.4	47	0.2
45-64 years	5,537	23.7	2,398	10.2	3,094	13.2	45	0.2
65 years and over	2,973	12.7	1,158	9.3	1,798	7.7	17	0.1
Not stated	353	1.5	54	0.2	58	0.2	241	1.0

Table 7. Number, percent, and cumulative percent of 7,514 ambulatory patient visits (ranked in decreasing frequency) to office-based physicians participating in Field Test: Phase II, NAMCS Feasibility Study, by the 20 most common three-digit ICDA categories assigned for patient's purpose, problem, or chief complaint: United States, 1971

[Diagnostic groupings and code number inclusions are based on the Eighth Revision International Classification of Diseases, Adapted for Use in the United States, 1965]

Rank	ICDA categories	Number of visits	Percent of visits	Cumulative percent
1	Medical or special examination Y00	966	12.9	12.9
2	Medical and surgical aftercare Y10	898	12.0	24.8
3	Prenatal care Y06	412	5.5	30.3
4	Symptoms referable to respiratory system 783	336	4.5	34.8
5	Other general symptoms 788	283	3.8	38.5
6	Symptoms referable to limbs and joints 787	281	3.7	42.3
7	Diagnostic category (and 3-digit ICDA code) not assigned	198	2.6	44.9
8	Acute pharyngitis 462	178	2.4	47.3
9	Symptoms referable to abdomen and lower gastrointestinal tract 785	174	2.3	49.6
10	Nervousness and debility 790	155	2.1	51.7
11	Vertebrogenic pain syndrome 728	149	2.0	53.6
12	Acute nasopharyngitis (common cold) 460	141	1.9	55.5
13	Persons receiving prophylactic inoculation and vaccination Y02	135	1.8	57.3
14	Other ill-defined and unknown causes of morbidity and mortality 796	133	1.8	59.1
15	Obesity not specified as of endocrine origin 277	122	1.6	60.7
16	Essential benign hypertension 401	121	1.6	62.3
17	Injury, other, and unspecified N996	120	1.6	63.9
18	Other eczema and dermatitis 692	118	1.6	65.5
19	Follow-up examination with no need for further care or need for only limited care Y03	89	1.2	66.7
20	Symptoms referable to genitourinary system 786	81	1.1	67.7
	Other specified diagnostic categories (with 3-digit ICDA codes assigned)	2,424	32.3	100.0

Table 8. Number, percent, and cumulative percent of 23,407 ambulatory patient visits (ranked in decreasing frequency) to office-based physicians participating in Field Test: Phase II, NAMCS Feasibility Study, by the 20 most common three-digit ICDA categories assigned for their most important diagnosis: United States, 1971

[Diagnostic groupings and code number inclusions are based on the Eighth Revision International Classification of Diseases, Adapted for Use in the United States, 1965]

Rank	ICDA categories	Number of visits	Percent of visits	Cumulative percent
1	Diagnostic category (and 3-digit ICDA code) not assigned	1,982	8.5	8.5
2	Medical and surgical aftercare .Y10	1,878	8.0	16.5
3	Medical or special examination .Y00	1,423	6.1	22.6
4	Prenatal care .Y06	751	3.2	25.8
5	Essential benign hypertension .401	699	3.0	28.8
6	Acute upper respiratory infection of multiple or unspecified sites .465	662	2.8	31.6
7	Neuroses .300	558	2.4	34.0
8	Chronic ischemic heart disease .412	445	1.9	35.9
9	Diabetes mellitus .250	362	1.6	37.4
10	Obesity not specified as of endocrine origin .277	346	1.5	38.9
11	Otitis media without mention of mastoiditis .381	324	1.4	40.3
12	Other eczema and dermatitis .692	314	1.3	41.6
13	Acute pharyngitis .462	313	1.3	43.0
14	Follow-up examination with no need for further care or need for only limited care .Y03	285	1.2	44.2
15	Bronchitis, unqualified .490	283	1.2	45.4
16	Hay fever .507	276	1.2	46.6
17	Sprains and strains of other and unspecified parts of back .N847	270	1.2	47.7
18	Acute tonsillitis .463	249	1.1	48.8
19	Other viral diseases .079	223	0.9	49.7
20	Diseases of sebaceous glands .706	212	0.9	50.7
20	Synovitis, bursitis, and tenosynovitis .731	212	0.9	51.6
	Other specified diagnostic categories (with 3-digit ICDA codes assigned)	11,340	48.4	100.0

Table 9. Number and percent distribution of 23,407 ambulatory patient visits (ranked in decreasing frequency) to office-based physicians participating in Field Test: Phase II, NAMCS Feasibility Study, by the 19 major ICDA classes containing their most important diagnosis: United States, 1971

[Diagnostic groupings and code number inclusions are based on the Eighth Revision International Classification of Diseases, Adapted for Use in the United States, 1965]

Rank	Major ICDA classes	Number of visits	Percent of visits
	Total, all visits	23,407	100.0
1	Supplementary classification: Special conditions and examinations without sickness Y00-Y13	4,779	20.1
2	VIII. Diseases of the respiratory system 460-519	3,056	13.1
3	Unknown diagnoses (with no code assigned)	1,982	8.5
4	VII. Diseases of the circulatory system 390-458	1,927	8.2
5	XVII. Accidents, poisonings, and violence N800-N999	1,879	8.0
6	VI. Diseases of the nervous system and sense organs 320-389	1,195	5.1
7	X. Diseases of the genitourinary system 580-629	1,191	5.1
8	XIII. Diseases of the musculoskeletal system and connective tissue 710-738	1,144	4.9
9	XII. Diseases of the skin and subcutaneous tissue 680-709	1,053	4.5
10	V. Mental disorders 290-315	988	4.2
11	III. Endocrine, nutritional, and metabolic diseases 240-279	980	4.2
12	XVI. Symptoms and ill-defined conditions 780-796	878	3.8
13	I. Infective and parasitic diseases 000-136	801	3.4
14	IX. Diseases of the digestive system 520-577	777	3.3
15	II. Neoplasms 140-239	397	1.7
16	IV. Diseases of blood and blood-forming organs 280-289	183	0.8
17	XIV. Congenital anomalies 740-759	136	0.6
18	XI. Complications of pregnancy, childbirth, and the puerperium 630-678	56	0.2
19	XV. Certain causes of perinatal morbidity and mortality 760-779	5	0.0

Table 10. Number and percent distribution of 7,514 ambulatory patient visits to office-based physicians participating in Field Test: Phase II, NAMCS Feasibility Study, by type of physician practice and color of patients: United States, 1971

Color of patients	Total, all types of practice		General and family practice		Specialty practice	
	Number	Percent distribution	Number	Percent distribution	Number	Percent distribution
Total, all visits	7,514	100.0	2,592	100.0	4,922	100.0
White	6,827	90.9	2,343	90.4	4,484	91.1
All other	643	8.6	233	9.0	410	8.3
Not stated	44	0.6	16	0.6	28	0.6

Table 11. Number and percent distribution of 7,514 ambulatory patient visits to office-based physicians participating in Field Test: Phase II, NAMCS Feasibility Study, by type of physician practice and marital status of patients: United States, 1971

Marital status of patients	Total, all types of practice		General and family practice		Specialty practice	
	Number	Percent distribution	Number	Percent distribution	Number	Percent distribution
Total, all visits	7,514	100.0	2,592	100.0	4,922	100.0
Single	2,598	34.6	823	31.8	1,775	36.1
Married	3,892	51.8	1,375	53.0	2,517	51.1
Widowed	442	5.9	157	6.1	285	5.8
Separated/divorced	237	3.2	113	4.4	124	2.5
Unknown	345	4.6	124	4.8	221	4.5

Table 12. Number and percent distribution of 7,514 ambulatory patient visits to office-based physicians participating in Field Test: Phase II, NAMCS Feasibility Study, by type of physician practice and by whether patient had been seen before by same physician: United States, 1971

Patient seen before by same physician	Total, all types of practice		General and family practice		Specialty practice	
	Number	Percent distribution	Number	Percent distribution	Number	Percent distribution
Total, all visits	7,514	100.0	2,592	100.0	4,922	100.0
Seen before	6,172	82.1	2,106	81.3	4,066	82.6
For present problem	4,377	58.3	1,261	48.6	3,116	63.3
Not for present problem	1,571	20.9	769	29.7	802	16.3
Unknown whether for present problem	224	3.0	76	2.9	148	3.0
Not seen before	1,308	17.4	469	18.1	839	17.0
Unknown whether seen before	34	0.5	17	0.7	17	0.3

Table 13. Number and percent of 7,514 ambulatory patient visits to office-based physicians participating in Field Test: Phase II, NAMCS Feasibility Study, by type of physician practice and extent of history taken and examination made at visit: United States, 1971

History taken and examination made at visit	Total, all types of practice		General and family practice		Specialty practice	
	Number	Percent	Number	Percent	Number	Percent
Total, all visits	7,514	100.0	2,592	100.0	4,922	100.0
Total, history taken	6,510	86.6	2,338	90.2	4,172	84.8
General history	2,121	28.2	722	27.9	1,399	28.4
Limited history	4,389	58.4	1,616	62.3	2,773	56.3
Total, history not taken	964	12.8	245	9.5	719	14.6
Total, unknown history	40	0.5	9	0.3	31	0.6
Total, examination made	6,783	90.3	2,399	92.6	4,384	89.1
General examination	2,109	28.1	678	26.2	1,431	29.1
Limited examination	4,674	62.2	1,721	66.4	2,953	60.0
Total, examination not made	641	8.5	174	6.7	467	9.5
Total, unknown examination	90	1.2	19	0.7	71	1.4

Table 14. Number and percent distribution of 7,514 ambulatory patient visits to office-based physicians participating in Field Test: Phase II, NAMCS Feasibility Study, by type of physician practice and laboratory procedure, X-ray examinations, and other diagnostic procedures ordered: United States, 1971

Diagnostic tests ordered at visit	Total, all types of practice		General and family practice		Specialty practice	
	Number	Percent distribution	Number	Percent distribution	Number	Percent distribution
Total, all visits	7,514	100.0	2,592	100.0	4,922	100.0
Lab procedures						
Total	1,991	26.5	523	20.2	1,468	29.8
For screening	1,000	13.3	222	8.6	778	15.8
For diagnosis	574	7.6	217	8.4	357	7.3
For followup	417	5.5	84	3.2	333	6.8
None ordered	5,095	67.8	1,821	70.3	3,274	66.5
Unknown	428	5.7	248	9.6	180	3.7
X-ray exams						
Total	710	9.4	220	8.5	490	10.0
For screening	176	2.3	52	2.0	124	2.5
For diagnosis	402	5.4	147	5.7	255	5.2
For followup	132	1.8	21	0.8	111	2.3
None ordered	6,040	80.4	2,072	79.9	3,968	80.6
Unknown	764	10.2	300	11.6	464	9.4
Other diagnostic procedures						
Total	565	7.5	112	4.3	453	9.2
For screening	192	2.6	42	1.6	150	3.0
For diagnosis	170	2.3	47	1.8	123	2.5
For followup	203	2.7	23	0.9	180	3.7
None ordered	6,104	81.2	2,159	83.3	3,945	80.2
Unknown	845	11.2	321	12.4	524	10.6

Table 15. Number and percent distribution of 7,514 ambulatory patient visits to office-based physicians participating in Field Test: Phase II, NAMCS Feasibility Study, by type of physician practice and diagnostic specimen taken: United States, 1971

Diagnostic specimen taken at visits	Total, all types of practice		General and family practice		Specialty practice	
	Number	Percent distribution	Number	Percent distribution	Number	Percent distribution
Total, all visits	7,514	100.0	2,592	100.0	4,922	100.0
Total, specimen taken	2,128	28.3	594	22.9	1,534	31.2
By physician	910	12.1	283	10.9	627	12.7
By staff	1,077	14.3	271	10.5	806	16.4
By other persons	141	1.9	40	1.5	101	2.1
No specimen taken	4,991	66.4	1,784	68.8	3,207	65.2
Unknown whether specimen taken	395	5.3	214	8.3	181	3.7

Table 16. Number and percent distribution of 23,407 ambulatory patient visits to office-based physicians participating in Field Test: Phase II, NAMCS Feasibility Study, by type of physician practice and treatment provided for patients: United States, 1971

Treatment provided for patients	Total, all types of practice		General and family practice		Specialty practice	
	Number	Percent distribution	Number	Percent distribution	Number	Percent distribution
Total, all visits[1]	23,407	100.0	7,932	100.0	15,475	100.0
None required	3,986	17.0	1,015	12.8	2,971	19.2
Drug therapy	12,065	51.5	5,399	68.1	6,666	43.1
Office surgical treatment	1,908	8.2	486	6.1	1,422	9.2
Therapeutic listening and/or psychotherapy	1,754	7.5	400	5.0	1,354	8.7
Advised diet, exercise, or habit changes	2,825	12.1	999	12.6	1,826	11.8
Family planning	293	1.3	90	1.1	203	1.3
Other treatment	5,872	25.1	1,394	17.6	4,478	28.9
Unknown treatment	194	0.8	63	0.8	131	0.8

[1] The sum of column entries exceeds column totals since more than 1 type of treatment may have been provided per visit.

Table 17. Number and percent distribution of 7,514 ambulatory patient visits to office-based physicians participating in Field Test: Phase II, NAMCS Feasibility Study, by type of physician practice and disposition following patient visit: United States, 1971

Disposition following patient visit	Total, all types of practice		General and family practice		Specialty practice	
	Number	Percent distribution	Number	Percent distribution	Number	Percent distribution
Total, all visits[1]	7,514	100.0	2,592	100.0	4,922	100.0
No further followup planned	670	8.9	293	11.3	377	7.7
Telephone followup planned	510	6.8	174	6.7	336	6.8
Return to same physician anytime, pro re nata	1,884	25.1	779	30.1	1,105	22.5
Return to same physician at specified time or interval	4,423	58.9	1,274	49.2	3,149	64.0
Referred for diagnostic tests only	72	1.0	21	0.8	51	1.0
Referred to another physician for consultation, diagnosis or treatment	181	2.4	71	2.7	110	2.2
Referred for hospital admission under same physician's care	236	3.1	45	1.7	191	3.9
Referred for hospital admission, under another physician's care	69	0.9	19	0.7	50	0.1
Returned to referring physician/agency	67	0.9	3	0.1	64	1.3
Other disposition	65	0.9	12	0.5	53	0.1

[1] The sum of column entries exceeds column totals since more than 1 kind of disposition may have been arranged per visit.

Table 18. Number and percent distribution of 7,514 ambulatory patient visits to office-based physicians participating in Field Test: Phase II, NAMCS Feasibility Study, by type of physician practice and duration of visit: United States, 1971

Duration of visit in minutes	Total, all types of practice		General and family practice		Specialty practice	
	Number	Percent distribution	Number	Percent distribution	Number	Percent distribution
Total, all visits	7,514	100.0	2,592	100.0	4,922	100.0
0-5 minutes	1,294	17.2	521	20.1	773	15.7
6-10 minutes	2,229	29.7	898	34.6	1,331	27.0
11-15 minutes	2,033	27.1	785	30.3	1,248	25.4
16-30 minutes	1,529	20.3	330	12.7	1,859	37.8
31-60 minutes	321	4.3	28	1.1	293	6.0
61 minutes and over	28	0.4	5	0.2	23	0.5
Unknown duration	80	1.1	25	1.0	55	1.1
Median, minutes	11.0		9.8		11.9	

APPENDIX I

DATA COLLECTION FORMS
1973 NATIONAL AMBULATORY MEDICAL CARE SURVEY

PATIENT LOG AND PATIENT RECORD, SAMPLING EVERY PATIENT

PATIENT LOG

DATE ___ ___ 19___

As each patient arrives, record his name on the log below, and complete the correspondingly numbered patient record to the right.

PATIENT NUMBER	PATIENT'S NAME
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	

PHYSICIAN'S COPY

ASSURANCE OF CONFIDENTIALITY—All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey and will not be disclosed or released to other persons or used for any other purpose.

A 121601

PATIENT RECORD
NATIONAL AMBULATORY MEDICAL CARE SURVEY

1. DATE OF VISIT — Mo / Day / Yr

2. DATE OF BIRTH — Mo / Day / Yr

3. SEX
- 1 ☐ FEMALE
- 2 ☐ MALE

4. COLOR OR RACE
- 1 ☐ WHITE
- 2 ☐ NEGRO/BLACK
- 3 ☐ OTHER
- 4 ☐ UNKNOWN

5. PATIENT'S PRINCIPAL PROBLEM(S) COMPLAINT(S), OR SYMPTOM(S) THIS VISIT (In patient's own words)
a. MOST IMPORTANT_____
b. OTHER_____

6. SERIOUSNESS OF PROBLEM IN ITEM 5a (Check one)
- 1 ☐ VERY SERIOUS
- 2 ☐ SERIOUS
- 3 ☐ SLIGHTLY SERIOUS
- 4 ☐ NOT SERIOUS

7. HAVE YOU EVER SEEN THIS PATIENT BEFORE?
- 1 ☐ YES
- 2 ☐ NO

If YES, for the problem indicated in ITEM 5a?
- 1 ☐ YES
- 2 ☐ NO

8. MAJOR REASON(S) FOR THIS VISIT (Check all major reasons)
- 01 ☐ ACUTE PROBLEM
- 02 ☐ ACUTE PROBLEM, FOLLOW-UP
- 03 ☐ CHRONIC PROBLEM, ROUTINE
- 04 ☐ CHRONIC PROBLEM, FLARE-UP
- 05 ☐ PRENATAL CARE
- 06 ☐ POSTNATAL CARE
- 07 ☐ POSTOPERATIVE CARE → [Operative procedure]
- 08 ☐ WELL ADULT/CHILD EXAM
- 09 ☐ FAMILY PLANNING
- 10 ☐ COUNSELING/ADVICE
- 11 ☐ IMMUNIZATION
- 12 ☐ REFERRED BY OTHER PHYS/AGENCY
- 13 ☐ ADMINISTRATIVE PURPOSE
- 14 ☐ OTHER (Specify)

9. PHYSICIAN'S PRINCIPAL DIAGNOSIS THIS VISIT
a. DIAGNOSIS ASSOCIATED WITH ITEM 5a ENTRY
b. OTHER SIGNIFICANT CURRENT DIAGNOSES (In order of importance)

10. TREATMENT/SERVICE ORDERED OR PROVIDED THIS VISIT (Check all that apply)
- 01 ☐ NONE ORDERED/PROVIDED
- 02 ☐ GENERAL HISTORY/EXAM
- 03 ☐ LAB PROCEDURE/TEST
- 04 ☐ X-RAYS
- 05 ☐ INJECTION/IMMUNIZATION
- 06 ☐ OFFICE SURGICAL TREATMENT (Specify)_____
- 07 ☐ PRESCRIPTION DRUG
- 08 ☐ NON-PRESCRIPTION DRUG
- 09 ☐ PSYCHOTHERAPY/THERAPEUTIC LISTENING
- 10 ☐ MEDICAL COUNSELING/ADVICE
- 11 ☐ OTHER (Specify)

11. DISPOSITION THIS VISIT (Check all that apply)
- 1 ☐ NO FOLLOW-UP PLANNED
- 2 ☐ RETURN AT SPECIFIED TIME
- 3 ☐ RETURN IF NEEDED, P.R.N.
- 4 ☐ TELEPHONE FOLLOW-UP PLANNED
- 5 ☐ REFERRED TO OTHER PHYSICIAN/AGENCY
- 6 ☐ RETURNED TO REFERRING PHYSICIAN
- 7 ☐ ADMIT TO HOSPITAL
- 8 ☐ OTHER (Specify)_____

12. DURATION OF THIS VISIT (Time actually spent with physician)
_____ MINUTES
–

HSM 666.2
REV. 4-73

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
NATIONAL CENTER FOR HEALTH STATISTICS

O.M.B. NO. 68-R73106
EXPIRATION DATE 6/30/73

FORM APPROVED - OMB NO. 68-R71006
EXP. 6/30/71

BEST COPY AVAILABLE

PATIENT LOG AND PATIENT RECORD, SAMPLING EVERY SECOND PATIENT

B 343202

ASSURANCE OF CONFIDENTIALITY — All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey and will not be disclosed or released to other persons or used for any other purpose.

B343202

PATIENT LOG

As each patient arrives, record name and time of visit on the log below. For the patient entered on line #3, also complete the patient record to the right.

PATIENT'S NAME	TIME OF VISIT
1	a.m. / p.m.
2	a.m. / p.m.

Record items 1-12 for this patient

CONTINUE LISTING PATIENTS ON NEXT PAGE

PATIENT RECORD
NATIONAL AMBULATORY MEDICAL CARE SURVEY

1. DATE OF VISIT — Mo / Day / Yr

2. DATE OF BIRTH — Mo / Day / Yr

3. SEX
- 1 ☐ FEMALE
- 2 ☐ MALE

4. COLOR OR RACE
- 1 ☐ WHITE
- 2 ☐ NEGRO/BLACK
- 3 ☐ OTHER
- 4 ☐ UNKNOWN

5. PATIENT'S PRINCIPAL PROBLEM(S) COMPLAINT(S), OR SYMPTOM(S) THIS VISIT (In patient's own words)
a. MOST IMPORTANT _____
b. OTHER _____

6. SERIOUSNESS OF PROBLEM IN ITEM 5a (Check one)
- 1 ☐ VERY SERIOUS
- 2 ☐ SERIOUS
- 3 ☐ SLIGHTLY SERIOUS
- 4 ☐ NOT SERIOUS

7. HAVE YOU EVER BEEN THIS PATIENT BEFORE?
- 1 ☐ YES
- 2 ☐ NO

If YES, for the problem indicated in ITEM 5a?
- 1 ☐ YES
- 2 ☐ NO

8. MAJOR REASON(S) FOR THIS VISIT (Check all major reasons)
- 01 ☐ ACUTE PROBLEM
- 02 ☐ ACUTE PROBLEM, FOLLOW-UP
- 03 ☐ CHRONIC PROBLEM, ROUTINE
- 04 ☐ CHRONIC PROBLEM, FLARE-UP
- 05 ☐ PRENATAL CARE
- 06 ☐ POSTNATAL CARE
- 07 ☐ POSTOPERATIVE CARE → _____ (Operative procedure)
- 08 ☐ WELL ADULT/CHILD EXAM
- 09 ☐ FAMILY PLANNING
- 10 ☐ COUNSELING/ADVICE
- 11 ☐ IMMUNIZATION
- 12 ☐ REFERRED BY OTHER PHYS/AGENCY
- 13 ☐ ADMINISTRATIVE PURPOSE
- 14 ☐ OTHER (Specify) _____

9. PHYSICIAN'S PRINCIPAL DIAGNOSIS THIS VISIT
a. DIAGNOSIS ASSOCIATED WITH ITEM 8a ENTRY _____
b. OTHER SIGNIFICANT CURRENT DIAGNOSES (In order of importance) _____

10. TREATMENT/SERVICE ORDERED OR PROVIDED THIS VISIT (Check all that apply)
- 01 ☐ NONE ORDERED/PROVIDED
- 02 ☐ GENERAL HISTORY/EXAM
- 03 ☐ LAB PROCEDURE/TEST
- 04 ☐ X-RAYS
- 05 ☐ INJECTION/IMMUNIZATION
- 06 ☐ OFFICE SURGICAL TREATMENT (Specify) _____
- 07 ☐ PRESCRIPTION DRUG
- 08 ☐ NON-PRESCRIPTION DRUG
- 09 ☐ PSYCHOTHERAPY/THERAPEUTIC LISTENING
- 10 ☐ MEDICAL COUNSELING/ADVICE
- 11 ☐ OTHER (Specify) _____

11. DISPOSITION THIS VISIT (Check all that apply)
- 1 ☐ NO FOLLOW-UP PLANNED
- 2 ☐ RETURN AT SPECIFIED TIME
- 3 ☐ RETURN IF NEEDED, P.R.N.
- 4 ☐ TELEPHONE FOLLOW-UP PLANNED
- 5 ☐ REFERRED TO OTHER PHYSICIAN/AGENCY
- 6 ☐ RETURNED TO REFERRING PHYSICIAN
- 7 ☐ ADMIT TO HOSPITAL
- 8 ☐ OTHER (Specify) _____

12. DURATION OF THIS VISIT (Time actually spent with physician)
_____ MINUTES

HSM 000 3
REV. 4-73

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
NATIONAL CENTER FOR HEALTH STATISTICS

O.M.B. 068-S72108
EXPIRATION DATE 6/30/75

PATIENT LOG AND PATIENT RECORD, SAMPLING EVERY THIRD PATIENT

C 487202

ASSURANCE OF CONFIDENTIALITY — All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey and will not be disclosed or released to other persons or used for any other purpose.

C 487202

PATIENT LOG

As each patient arrives, record name and time of visit on the log below. For the patient entered on line #3, also complete the patient record to the right.

PATIENT'S NAME	TIME OF VISIT
1	a.m. / p.m.
2	a.m. / p.m.
3	a.m. / p.m.

Record items 1-12 for this patient

CONTINUE LISTING PATIENTS ON NEXT PAGE

PATIENT RECORD
NATIONAL AMBULATORY MEDICAL CARE SURVEY

1. DATE OF VISIT — Mo / Day / Yr

2. DATE OF BIRTH — Mo / Day / Yr

3. SEX
- 1 ☐ FEMALE
- 2 ☐ MALE

4. COLOR OR RACE
- 1 ☐ WHITE
- 2 ☐ NEGRO/BLACK
- 3 ☐ OTHER
- 4 ☐ UNKNOWN

5. PATIENT'S PRINCIPAL PROBLEM(S) COMPLAINT(S), OR SYMPTOM(S) THIS VISIT (In patient's own words)
a. MOST IMPORTANT _____
b. OTHER _____

6. SERIOUSNESS OF PROBLEM IN ITEM 5a (Check one)
- 1 ☐ VERY SERIOUS
- 2 ☐ SERIOUS
- 3 ☐ SLIGHTLY SERIOUS
- 4 ☐ NOT SERIOUS

7. HAVE YOU EVER BEEN THIS PATIENT BEFORE?
- 1 ☐ YES
- 2 ☐ NO

If YES, for the problem indicated in ITEM 5a?
- 1 ☐ YES
- 2 ☐ NO

8. MAJOR REASON(S) FOR THIS VISIT (Check all major reasons)
- 01 ☐ ACUTE PROBLEM
- 02 ☐ ACUTE PROBLEM, FOLLOW-UP
- 03 ☐ CHRONIC PROBLEM, ROUTINE
- 04 ☐ CHRONIC PROBLEM, FLARE-UP
- 05 ☐ PRENATAL CARE
- 06 ☐ POSTNATAL CARE
- 07 ☐ POSTOPERATIVE CARE → _____ (Operative procedure)
- 08 ☐ WELL ADULT/CHILD EXAM
- 09 ☐ FAMILY PLANNING
- 10 ☐ COUNSELING/ADVICE
- 11 ☐ IMMUNIZATION
- 12 ☐ REFERRED BY OTHER PHYS/AGENCY
- 13 ☐ ADMINISTRATIVE PURPOSE
- 14 ☐ OTHER (Specify) _____

9. PHYSICIAN'S PRINCIPAL DIAGNOSIS THIS VISIT
a. DIAGNOSIS ASSOCIATED WITH ITEM 8a ENTRY _____
b. OTHER SIGNIFICANT CURRENT DIAGNOSES (In order of importance) _____

10. TREATMENT/SERVICE ORDERED OR PROVIDED THIS VISIT (Check all that apply)
- 01 ☐ NONE ORDERED/PROVIDED
- 02 ☐ GENERAL HISTORY/EXAM
- 03 ☐ LAB PROCEDURE/TEST
- 04 ☐ X-RAYS
- 05 ☐ INJECTION/IMMUNIZATION
- 06 ☐ OFFICE SURGICAL TREATMENT (Specify) _____
- 07 ☐ PRESCRIPTION DRUG
- 08 ☐ NON-PRESCRIPTION DRUG
- 09 ☐ PSYCHOTHERAPY/THERAPEUTIC LISTENING
- 10 ☐ MEDICAL COUNSELING/ADVICE
- 11 ☐ OTHER (Specify) _____

11. DISPOSITION THIS VISIT (Check all that apply)
- 1 ☐ NO FOLLOW-UP PLANNED
- 2 ☐ RETURN AT SPECIFIED TIME
- 3 ☐ RETURN IF NEEDED, P.R.N.
- 4 ☐ TELEPHONE FOLLOW-UP PLANNED
- 5 ☐ REFERRED TO OTHER PHYSICIAN/AGENCY
- 6 ☐ RETURNED TO REFERRING PHYSICIAN
- 7 ☐ ADMIT TO HOSPITAL
- 8 ☐ OTHER (Specify) _____

12. DURATION OF THIS VISIT (Time actually spent with physician)
_____ MINUTES

HSM 000 4
REV. 4-73

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
NATIONAL CENTER FOR HEALTH STATISTICS

O.M.B. 068-S72108
EXPIRATION DATE 6/30/75

PATIENT LOG AND PATIENT RECORD, SAMPLING EVERY FIFTH PATIENT

BEST COPY AVAILABLE

D691705

PATIENT LOG

As each patient arrives, record name and time of visit on the log below. For the patient entered on line #5, also complete the patient record to the right.

PATIENT'S NAME	TIME OF VISIT
1	a.m. / p.m.
2	a.m. / p.m.
3	a.m. / p.m.
4	a.m. / p.m.
5	a.m. / p.m.
6	a.m. / p.m.

Record items 1-12 for this patient

CONTINUE LISTING PATIENTS ON NEXT PAGE

ASSURANCE OF CONFIDENTIALITY — All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey and will not be disclosed or released to other persons or used for any other purpose.

D691705

PATIENT RECORD
NATIONAL AMBULATORY MEDICAL CARE SURVEY

1. DATE OF VISIT — Mo / Day / Yr

2. DATE OF BIRTH — Mo / Day / Yr

3. SEX
- 1 ☐ FEMALE
- 2 ☐ MALE

4. COLOR OR RACE
- 1 ☐ WHITE
- 2 ☐ NEGRO/BLACK
- 3 ☐ OTHER
- 4 ☐ UNKNOWN

5. PATIENT'S PRINCIPAL PROBLEM(S), COMPLAINT(S), OR SYMPTOM(S) THIS VISIT *(In patient's own words)*

a. MOST IMPORTANT _____

b. OTHER _____

6. SERIOUSNESS OF PROBLEM IN ITEM 5a *(Check one)*
- 1 ☐ VERY SERIOUS
- 2 ☐ SERIOUS
- 3 ☐ SLIGHTLY SERIOUS
- 4 ☐ NOT SERIOUS

7. HAVE YOU EVER SEEN THIS PATIENT BEFORE?
- 1 ☐ YES
- 2 ☐ NO

If YES, for the problem indicated in ITEM 5a?
- 1 ☐ YES
- 2 ☐ NO

8. MAJOR REASON(S) FOR THIS VISIT *(Check all major reasons)*
- 01 ☐ ACUTE PROBLEM
- 02 ☐ ACUTE PROBLEM, FOLLOW-UP
- 03 ☐ CHRONIC PROBLEM, ROUTINE
- 04 ☐ CHRONIC PROBLEM, FLARE-UP
- 05 ☐ PRENATAL CARE
- 06 ☐ POSTNATAL CARE
- 07 ☐ POSTOPERATIVE CARE → _____ *(Operative procedure)*
- 08 ☐ WELL ADULT/CHILD EXAM
- 09 ☐ FAMILY PLANNING
- 10 ☐ COUNSELING/ADVICE
- 11 ☐ IMMUNIZATION
- 12 ☐ REFERRED BY OTHER PHYS/AGENCY
- 13 ☐ ADMINISTRATIVE PURPOSE
- 14 ☐ OTHER *(Specify)* _____

9. PHYSICIAN'S PRINCIPAL DIAGNOSIS THIS VISIT

a. DIAGNOSIS ASSOCIATED WITH ITEM 5a ENTRY

b. OTHER SIGNIFICANT CURRENT DIAGNOSES *(In order of importance)*

10. TREATMENT/SERVICE ORDERED OR PROVIDED THIS VISIT *(Check all that apply)*
- 01 ☐ NONE ORDERED/PROVIDED
- 02 ☐ GENERAL HISTORY/EXAM
- 03 ☐ LAB PROCEDURE/TEST
- 04 ☐ X-RAYS
- 05 ☐ INJECTION/IMMUNIZATION
- 06 ☐ OFFICE SURGICAL TREATMENT *(Specify)* _____
- 07 ☐ PRESCRIPTION DRUG
- 08 ☐ NON-PRESCRIPTION DRUG
- 09 ☐ PSYCHOTHERAPY/THERAPEUTIC LISTENING
- 10 ☐ MEDICAL COUNSELING/ADVICE
- 11 ☐ OTHER *(Specify)* _____

11. DISPOSITION THIS VISIT *(Check all that apply)*
- 1 ☐ NO FOLLOW-UP PLANNED
- 2 ☐ RETURN AT SPECIFIED TIME
- 3 ☐ RETURN IF NEEDED, P.R.N.
- 4 ☐ TELEPHONE FOLLOW-UP PLANNED
- 5 ☐ REFERRED TO OTHER PHYSICIAN/AGENCY
- 6 ☐ RETURNED TO REFERRING PHYSICIAN
- 7 ☐ ADMIT TO HOSPITAL
- 8 ☐ OTHER *(Specify)* _____

12. DURATION OF THIS VISIT *(Time actually spent with physician)*

_____ MINUTES

HSM 888.5
REV. 6-73

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
NATIONAL CENTER FOR HEALTH STATISTICS

O.M.B. #68-R72108
EXPIRATION DATE 6/30/75

INDUCTION INTERVIEW SCHEDULE

CONFIDENTIAL*
NORC-4155
Feb., 1973

Form Approved.
OMB No. 068-S72106
Expires: June 30, 1974

NATIONAL AMBULATORY MEDICAL CARE SURVEY

TIME BEGAN: _____ AM PM

INDUCTION INTERVIEW

(Phys. ID Number)

BEFORE STARTING INTERVIEW

1. ENTER PHYSICIAN I.D. NUMBER IN BOX TO RIGHT, ABOVE
2. ENTER DATES OF ASSIGNED REPORTING WEEK IN Q. 3, P.2

Doctor, before I begin, let me take a minute to give you a little background about this survey.

Although ambulatory medical care accounts for nearly 90 per cent of all medical care received in the United States, there is no systematic information about the characteristics and problems of people who consult physicians in their offices. This kind of information has been badly needed by medical educators and others concerned with the medical manpower situation.

In response to increasing demands for this kind of information, the National Center for Health Statistics has conducted a series of feasibility studies to determine whether a workable data collection method could be developed. In close consultation with representatives of the medical profession, this National Ambulatory Medical Care Survey was designed and tested.

Your own task in the survey is simple, carefully designed, and should not take much of your time. Essentially, it consists of your participation during a specified 7-day period. During this period, you simply check off a minimal amount of information concerning the patients you see.

Now, before we get into the actual procedures, I have a few questions to ask about your practice. The answers you give me will be used only for classification and analysis, and of course all information you provide is held in strict confidence.

1. First, you are a _____. Is that right?
(ENTER SPECIALTY FROM CODE ON FACE SHEET LABEL.)

Yes 1
No . (ASK A) . . 2

A. IF NO: What is your specialty, (including general practice)?

_____
(Name of Specialty)

---

*All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used only by persons engaged in and for the purpose of the survey, and will not be disclosed or released to other persons or used for any other purpose.

2. Do you have a solo practice, or are you associated with other physicians in a partnership, in a group practice, or in some other way?

Solo 1
Partnership . . . (ASK A) . . . 2
Group . . . (ASK A) 3
Other . (SPECIFY AND ASK A) . . 4

_____

A. IF PARTNERSHIP, GROUP, OR OTHER: How many other physicians are associated with you?

_____
(# of Physicians)

---

3. Now, doctor, this study will be concerned with the ambulatory patients you will see in your office during the week of (READ REPORTING DATES ENTERED BELOW.

_____/_____ (that's a Monday) through _____/_____ (that's a Sunday)
month date month date

Are you likely to see any ambulatory patients in your office during that week?

Yes . . . (GO TO Q. 4) . . . 1
No . . . . . (ASK A) . . . 2

A. IF NO: Why is that? RECORD VERBATIM, THEN READ PARAGRAPH BELOW

Since it's very important, doctor, that we include any ambulatory patients that you do happen to see in your office during that week, I'd like to leave these forms with you anyway--just in case your plans change. I'll plan to check back with your office just before (STARTING DATE) to make sure, and I can explain them in detail then, if necessary.

GIVE DOCTOR THE A PATIENT RECORD FORMS AND GO TO Q. 10, P. 6.

4. A. At what office location will you be seeing ambulatory patients during that 7-day period? RECORD UNDER A BELOW AND ASK B WHEN INDICATED.

B. IF HOSPITAL EMERGENCY ROOM, OUT-PATIENT CLINIC, OR OTHER INSTITUTIONAL LOCATION IN A: Thinking about the ambulatory patients you see in (PLACE IN A), do you, yourself, have primary responsibility for their care over time, or does (INSTITUTION IN A) have primary responsibility for their care over time? CODE UNDER B BELOW.

A. Office Location	B. Dr. has prime responsibility (in scope)	B. Inst. has prime responsibility (out-of-scope)
(1) _____	1	0
(2) _____	1	0
(3) _____	1	0
(4) _____	1	0

C. Is that all of the office locations at which you expect to see ambulatory patients during that week?

Yes 1
No 2

IF NO: OBTAIN OFFICE LOCATION(S), ENTER IN "A" ABOVE, AND REPEAT.

IF ALL LOCATIONS ARE OUT-OF-SCOPE (CODE "0" IN Q. 4B), THANK THE DOCTOR AND LEAVE.

5. A. During that week (REPEAT DATES), how many ambulatory patients do you expect to see in your office practice? (DO NOT COUNT PATIENTS SEEN AT [OUT-OF-SCOPE LOCATIONS] CODED IN 4-B.)

ENTER TOTAL UNDER "A" BELOW AND CIRCLE ON APPROPRIATE LINE.

B. And during those seven days (REPEAT DATES IF NECESSARY), on how many days do you expect to see any ambulatory patients? COUNT EACH DAY IN WHICH DOCTOR EXPECTS TO SEE ANY PATIENTS AT AN IN-SCOPE OFFICE LOCATION.

ENTER TOTAL UNDER "B" BELOW AND CIRCLE NUMBER IN APPROPRIATE COLUMN.

DETERMINE PROPER PATIENT LOG FORM FROM CHART BELOW. READ ACROSS ON "TOTAL PATIENTS" LINE UNDER "A" AND CIRCLE LETTER IN APPROPRIATE "DAYS" COLUMN UNDER "B."

THIS LETTER TELLS YOU WHICH OF THE FOUR PATIENT LOG FORMS (A, B, C, D) SHOULD BE USED BY THIS DOCTOR.

LOG FORM DESCRIPTION	A. Expected total patients during survey week. ENTER TOTAL FROM Q. 5-A. _____	B. Total days in practice during week. ENTER TOTAL FROM Q. 5-B. _____ DAYS						
		1	2	3	4	5	6	7
A--Patient Record is to be completed for ALL patients listed on Log.	1- 10 PATIENTS	A	A	A	A	A	A	A
	11- 20	B	A	A	A	A	A	A
B--Patient Record is to be completed for every SECOND patient listed on Log.	21- 30	C	B	A	A	A	A	A
	31- 40	C	B	B	A	A	A	A
	41- 50	D	C	B	B	A	A	A
	51- 60	D	C	B	B	B	A	A
C--Patient Record is to be completed for every THIRD patient listed on Log.	61- 70	D	D	C	B	B	B	A
	71- 80	D	D	C	B	B	B	B
	81- 90	D	D	C	B	B	B	B
	91-100	D	D	C	C	B	B	B
	101-110	D	D	C	C	B	B	B
*D--Patient Record is to be completed for every FIFTH patient listed on Log.	111-120	D	D	D	C	B	B	B
	121-130	D	D	D	C	C	B	B
	131-140	D	D	D	C	C	C	B
	141-150	D	D	D	D	C	C	C
	151-160	D	D	D	D	C	C	C
	161-170	D	D	D	D	D	C	C
	171-180	D	D	D	D	D	C	C
	181-190	D	D	D	D	D	C	C
	191-200	D	D	D	D	D	D	C
	200- +	D	D	D	D	D	D	D

*In the rare instance the physician will see more than 500 patients during his assigned reporting week, give him two D Patient Log Folios and instruct him to complete a patient record form for only every tenth patient. Then you are to draw an X or line on line 5 on every other page of the two folio pads, starting with page 1 of the pad.

6. FIND PATIENT LOG FOLIO WITH APPROPRIATE LETTER AND ENTER LETTER AND NUMBER OF THIS FORM HERE.

_____
(Folio Number)

7. HAND DOCTOR HIS FOLIO AND EXPLAIN HOW FORMS ARE TO BE FILLED OUT. SHOW DOCTOR THE INSTRUCTIONS ON POCKET OF FOLIO TO WHICH HE CAN REFER AFTER YOU LEAVE.

RECORD VERBATIM BELOW ANY CONCERN, PROBLEMS OR QUESTIONS THE DOCTOR RAISES.

8. IF DOCTOR EXPECTS TO SEE AMBULATORY PATIENTS AT MORE THAN ONE IN-SCOPE LOCATION DURING ASSIGNED WEEK, TELL HIM YOU WILL DELIVER THE FORMS TO THE OTHER LOCATION(S). ENTER THE FORM LETTER AND NUMBER(S) FOR THOSE LOCATIONS BELOW, BEFORE DELIVERING FORM(S).

Location	Patient Record Form Letter & Number

9. During the survey week (REPEAT EXACT DATES), will anyone be available to help you in filling out these records (at each IN-SCOPE location)?

Yes . . . (ASK A) . . 1

No 2

A. IF YES: Who would that be?
RECORD NAME, POSITION AND LOCATION.

Name	Position	Location	B. *INTERVIEWER: WAS PERSON BRIEFED BY YOU? Yes	No
			1	2
			1	2
			1	2
			1	2

*INTERVIEWER SHOULD BRIEF SUCH PERSON IF POSSIBLE.

10. Now I have just one more question about your practice. (NOTE: IF DOCTOR PRACTICES IN LARGE GROUP, THE FOLLOWING INFORMATION CAN BE OBTAINED FROM SOMEONE ELSE.)

A. What is the total number of full-time (35 hours or more per week) employees of your (partnership/group) practice? Include persons regularly employed who are now on vacation, temporarily ill, etc. Do <u>not</u> include other physicians. RECORD ON TOP LINE OF COLUMN A BELOW.

1) How many of these full-time employees are . . . (READ CATEGORIES BELOW AS NECESSARY AND RECORD NUMBER OF EACH IN COLUMN A.)

B. And what is the total number of part-time (less than 35 hours per week) employees of your (partnership/group) practice? Again, include persons regularly employed who are now on vacation, ill, etc. Do not include other physicians. RECORD ON TOP LINE OF COLUMN B BELOW.

1) How many of these part-time employees are . . . (READ CATEGORIES AS NECESSARY AND RECORD NUMBER OF EACH IN COLUMN B.)

Employees	A. <u>Full-time</u> (35 or more hours/week)	B. <u>Part-time</u> (Less than 35 hours/week)
	TOTAL: _____	TOTAL: _____
(1) Registered Nurse	_____	_____
(2) Licensed Practical Nurse	_____	_____
(3) Nursing Aide	_____	_____
(4) Physician Assistant	_____	_____
(5) Technician	_____	_____
(6) Secretary or Receptionist	_____	_____
(7) Other (Specify)	_____	_____

BEFORE YOU LEAVE, STRESS THAT EACH AMBULATORY PATIENT SEEN BY THE DOCTOR DURING THE 7-DAY PERIOD AT ALL IN-SCOPE OFFICE LOCATIONS (REPEAT THEM) IS TO BE INCLUDED IN THE SURVEY, THAT EACH PATIENT IS TO BE RECORDED ON THE LOG, AND ONLY THE APPROPRIATE NUMBER OF PATIENT RECORDS COMPLETED.

Thank you for your time, Dr. _____. If you have any (more) questions, please feel free to call me. My phone number is written in the folio. I'll call you on Monday morning of your survey week just to remind you.

11. TIME INTERVIEW ENDED . . . . . _____ AM PM

12. DATE OF INTERVIEW . . . . . | | | | | | | (Month) (Day) (Year)

COMPLETE ITEMS ON LAST PAGE

IMMEDIATELY AFTER THE INTERVIEW

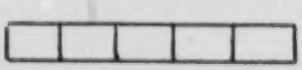
I. How much interest do you think the doctor has in the survey?

- Great interest 1
- Some interest 2
- Little interest 3
- No interest 4
- Can't tell 5

II. How confident are you that the doctor will complete the forms?

- Definitely will 1
- Probably will 2
- Doubtful 3

INTERVIEWER NUMBER



INTERVIEWER'S SIGNATURE

APPENDIX II

INTRODUCTORY LETTERS

1973 NATIONAL AMBULATORY MEDICAL CARE SURVEY

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
ROCKVILLE, MARYLAND 20852

NATIONAL CENTER FOR
HEALTH STATISTICS

Endorsing Organizations

American Medical Association
E. B. Howard, M.D.
Executive Vice President

National Medical Association
Robert Watkins
Executive Vice President

American Academy of Dermatology
Frederick A. J. Kingery, M.D.
Secretary-Treasurer

American Academy of Family Physicians
Roger Tusken
Executive Director

American Academy of Neurology
Stanley A. Nelson
Executive Secretary

American Academy of Orthopaedic Surgeons
Charles V. Heck, M.D.
Executive Director

American Academy of Pediatrics
Robert G. Frazier, M.D.
Executive Director

American Association of Neurological Surgeons
Gordon van den Noort, M.D.
Secretary

American College of Obstetricians and Gynecologists
Michael Newton, M.D.
Director

American College of Physicians
Edward C. Rosenow, Jr., M.D.
Executive Vice President

American College of Preventive Medicine
Ward Bensley
Executive Director

American College of Surgeons
C. Rollins Hanlon, M.D.
Executive Director

American Osteopathic Association
Edward P. Crowell, D.O.
Executive Director

American Protologic Society
John E. Ray, M.D.
President

American Psychiatric Association
Walter E. Barton, M.D.
Medical Director

American Society of Internal Medicine
William R. Ramsey
Executive Director

American Society of Plastic and Reconstructive Surgeons, Inc.
Dallas F. Whaley
Executive Vice President

American Urologic Association
Wyland F. Leadbetter, M.D.
President

Association of American Medical Colleges
John A. D. Cooper, M.D., Ph.D.
President

Dear Dr. :

The National Center for Health Statistics, as part of its continuing program to provide information on the health status of the American people, is conducting a National Ambulatory Medical Care Survey (NAMCS).

The purpose of this survey is to collect information about ambulatory patients, their problems, and the resources used for their care. The resulting published statistics will help your profession plan for more effective health services, determine health manpower requirements, and improve medical education.

Since practicing physicians are the only reliable source of this information, we need your assistance in the NAMCS. As one of the physicians selected in our national sample, your participation is essential to the success of the survey. Of course, all information that you provide is held in strict confidence.

Many organizations and leaders in the medical profession have expressed their support for this survey, including those shown to the left. In particular, your own specialty society has reviewed the NAMCS program and supports this effort (see enclosure). They join me in urging your cooperation in this important research.

Within a few days, a survey representative will telephone you for an appointment to discuss the details of your participation. We greatly appreciate your cooperation.

Sincerely yours,

Edward B. Perrin, Ph.D.
Acting Director

Enclosure

AMERICAN MEDICAL ASSOCIATION

535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 527-1500 • TWX 910-221-0300

ERNEST B. HOWARD, M.D.
Executive Vice President

Dear Doctor

The National Center for Health Statistics is conducting a survey to collect data on office-based ambulatory medical care. We urge you to cooperate in this survey from which we expect to obtain data of value to the medical profession in planning and organizing health services, in planning for the efficient utilization of health facilities and manpower, and in determining desirable modifications in medical education programs.

The American Medical Association is keenly interested in having accurate information about medical care services provided by physicians in private practice and was represented on the Technical Advisory Panel which was consulted about the type and amount of patient information to be collected and the survey procedures to be used. The survey has been designed to require a minimal amount of recordkeeping and to ensure confidentiality of information on patients from physicians. Data from the survey will be presented in summary form.

If you wish more details about the survey or the amount of time it will involve, please contact Mr. Theodore Woolsey, Director, National Center for Health Statistics, 5600 Fishers Lane, Rockville, Maryland 20852.

I believe the data to be collected will be of value to the medical profession and urge you to support the study by providing the information requested.

Sincerely,

Ernest B. Howard

Ernest B. Howard, M. D.

APPENDIX III

DATA COLLECTION FORMS
FIELD TEST: PHASE I

LONG FORM—PATIENT DATA

PATIENT'S NAME (OPTIONAL) _____

SURVEY OF AMBULATORY MEDICAL CARE

PHYSICIAN'S COPY

96426

REASONS FOR THIS CONTACT

Patient's purpose, problem or chief complaint _____

Most important diagnosis (definite or provisional) _____

Other diagnoses _____

LOCATION OF THIS CONTACT

- My office or clinic ☐
- Telephone (other than for appointment) ☐
- Emergency room ☐
- Outpatient clinic (hospital) ☐
- Home of patient ☐
- Other (specify) _____ ☐

PATIENT CHARACTERISTICS

AGE

_____Years

_____Months (infant)

SEX

- Male ☐
- Female ☐

COLOR OR RACE

- White ☐
- Negro ☐
- Other ☐
- Unknown ☐

CURRENT MARITAL STATUS

- Never married ☐
- Married ☐
- Widowed ☐
- Separated or divorced ☐
- Unknown ☐

SOCIO-ECONOMIC STATUS

- Upper ☐
- Middle ☐
- Lower ☐
- Unknown ☐

PATIENT SEEN BY YOU BEFORE?

- Yes ☐
- No ☐

IF YES, FOR THE PRESENT PROBLEM OR COMPLAINT?

- Yes ☐
- No ☐

HEALTH STATUS

- Essentially healthy ☐
- Slightly ill ☐
- Moderately ill ☐
- Seriously ill ☐
- Unknown ☐

REFERRAL STATUS

- Referred by another physician ☐
- Referred by other person or agency ☐
- Not referred (or self-referred) ☐
- Unknown ☐

SERIOUSNESS OF PATIENT'S PROBLEM OR COMPLAINT

In your opinion, how serious did the patient consider his problem to be?		Based on your clinical judgment, how serious was the problem in actuality?	
Very serious	☐	Very serious	☐
Moderately serious	☐	Moderately serious	☐
Slightly serious	☐	Slightly serious	☐
Not serious	☐	Not serious	☐
Unknown	☐		

DIAGNOSTIC PROCEDURES

HISTORY — General ☐ Limited ☐ None ☐

EXAMINATION — General ☐ Limited ☐ None ☐

DIAGNOSTIC TESTS ORDERED THIS VISIT? Yes ☐ No ☐

IF YES, PURPOSE OF TESTS

	None	Screening	Diagnosis	Follow-up
LABORATORY PROCEDURES	☐			
Urine sugar		☐	☐	☐
Urine protein		☐	☐	☐
Urine microscopy		☐	☐	☐
Hemoglobin or hematocrit		☐	☐	☐
WBC count		☐	☐	☐
Differential WBC count		☐	☐	☐
Prothrombin time		☐	☐	☐
Bacteriologic culture		☐	☐	☐
Cervical cytology		☐	☐	☐
Blood sugar		☐	☐	☐
BUN/NPN		☐	☐	☐
Other (specify)		☐	☐	☐
X-RAY EXAMINATIONS	☐			
Chest		☐	☐	☐
Skeletal structure		☐	☐	☐
GI series, upper		☐	☐	☐
Gallbladder series		☐	☐	☐
Other (specify)		☐	☐	☐
SPECIAL PROCEDURES	☐			
ECG interpretation		☐	☐	☐
Endoscopic examination		☐	☐	☐
Other (specify)		☐	☐	☐
OTHER DIAGNOSTIC PROCEDURES NOT LISTED (SPECIFY)		☐	☐	☐

SPECIMEN TAKEN THIS VISIT? Yes ☐ No ☐

IF YES, TAKEN BY

	Physician	Staff	Other
Blood	☐	☐	☐
Smear from pharynx	☐	☐	☐
ECG tracing	☐	☐	☐
Smear from cervix	☐	☐	☐
Other (specify)	☐	☐	☐

MANAGEMENT

TREATMENT (advised, prescribed, dispensed, administered or arranged)

- None required ☐
- Drug therapy ☐
- Immunizations ☐
- Surgical procedures or treatments (specify) ☐

_____

- Advised diet, exercise or behavior change ☐
- Advised bed or house rest ☐
- Other health education or counseling ☐
- Therapeutic listening ☐
- Psychotherapy ☐
- Physical therapy ☐
- Administrative procedures ☐
- Other (specify) ☐

_____

DISPOSITION

- No further follow-up planned ☐
- Telephone follow-up planned ☐
- Return to see at any time, p.r.n. ☐
- Return to see at specified time or interval ☐
- Referred for diagnostic tests only ☐
- Referred to another physician for consultation, diagnosis or treatment ☐
- Referred for hospital admission
  - Under my care ☐
  - Under another physician's care ☐
- Returned to referring physician or agency ☐
- Other (specify) _____ ☐

CONFIDENTIAL — All information which would permit identification of an individual or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey and will not be disclosed or released to other persons or used for any other purpose.

Form Approved: Budget Bureau No. 68-S[illegible]

SHORT FORM—PATIENT DATA

PATIENT'S NAME (OPTIONAL) _____

SURVEY OF AMBULATORY MEDICAL CARE

PHYSICIAN'S COPY

49416

REASONS FOR THIS CONTACT

Patient's purpose, problem or chief complaint

_____

Most important diagnosis (definite or provisional)

_____

Other diagnoses

LOCATION OF THIS CONTACT

DURATION (IN MINUTES) ☐

- My office or clinic ☐
- Telephone (other than for appointment) ☐
- Emergency room ☐
- Outpatient clinic (hospital) ☐
- Home of patient ☐
- Other (specify) _____ ☐

MANAGEMENT

TREATMENT (given, prescribed, dispensed, administered or arranged)

- None required ☐
- Drug therapy ☐
- Surgical procedures or treatments (specify) ☐

_____

- Therapeutic listening or advising ☐
- Administrative procedures ☐
- Other (specify) _____ ☐

PATIENT CHARACTERISTICS

AGE

_____ Years

_____ Months (infant)

SEX

- Male ☐
- Female ☐

CURRENT MARITAL STATUS

- Never married ☐
- Married ☐
- Widowed ☐
- Separated or divorced ☐
- Unknown ☐

COLOR OR RACE

- White ☐
- Negro ☐
- Other ☐
- Unknown ☐

PATIENT SEEN BY YOU BEFORE?

- Yes ☐
- No ☐

IF YES, FOR THIS PRESENT PROBLEM OR COMPLAINT?

- Yes ☐
- No ☐

DIAGNOSTIC PROCEDURES

HISTORY	General ☐	EXAMINATION	General ☐
	Limited ☐		Limited ☐
	None ☐		None ☐

DIAGNOSTIC TESTS ORDERED THIS VISIT? Yes ☐ No ☐

	IF YES, PURPOSE OF TESTS		
	Screening	Diagnosis	Follow-up
LABORATORY PROCEDURES	☐	☐	☐
X-RAY EXAMINATIONS	☐	☐	☐
SPECIAL PROCEDURES	☐	☐	☐

SPECIMEN TAKEN THIS VISIT FOR LABORATORY PROCEDURES BY

None ☐ Physician ☐ Staff ☐ Other ☐

CONFIDENTIAL — All information which would permit identification of an individual or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey and will not be disclosed or released to other persons or used for any other purpose.

DISPOSITION

- No further follow-up planned ☐
- Telephone follow-up planned ☐
- Return to me at any time, p.r.n. ☐
- Return to me at specified time or interval ☐
- Referred for diagnostic test only ☐
- Referred to another physician for consultation, diagnosis or treatment ☐
- Referred for hospital admission
  - Under my care ☐
  - Under another physician's care ☐
- Returned to referring physician or agency ☐
- Other (specify) _____ ☐

Form Approved - Budget Bureau No. 68 — S2R04

INDUCTION INTERVIEW SCHEDULE

ED	
1 - 4	
5	
6 - 7	
8	
9	
FOR CODERS	

03500

INDUCTION INTERVIEW -

SURVEY OF AMBULATORY MEDICAL CARE

DATE OF INTERVIEW: _____ INTERVIEWER'S NO: _____

CITY WHERE INTERVIEWED: _____

INTERVIEWER'S COMMENTS - RECORD ALL SIGNIFICANT OBSERVATIONS RELATING TO YOUR CONTACT WITH THIS DOCTOR:

_____

_____

_____

_____

_____

_____

RESPONDENT: _____
(Print Last Name First Name Initial)

_____
(Print Street Address)

_____ _____
(Print City State Zip)

INTERVIEWER'S NAME: _____

Form Approved - Budget Bureau No. 68-S68099

SAMC INDUCTION QUESTIONNAIRE

Doctor, I would like to ask you a few questions to make sure we have identified you properly.

1. First, you are a _____(SPECIALTY)_____, is that right?

( ) Yes ( ) No - What is your specialty, doctor?

_____

_____

2a. Do you practice ( ) solo or ( ) in a group or partnership? (Check one)

b. (IF GROUP OR PARTNERSHIP) How many physicians are associated with you?

_____ physicians

3. Do you treat any <u>ambulatory</u> patients in your practice?

( ) Yes (CONTINUE INTERVIEW)

( ) No - I treat no ambulatory patients (TERMINATE INTERVIEW)

( ) No - I am no longer in practice (TERMINATE INTERVIEW)

4a. Would you tell me about how many hours you spend in a typical week in direct patient care and counseling?

_____ hours

b. How many hours each week in other professional activity such as teaching, research, administration and continuing education?

_____ hours

c. How many weeks per year do you usually practice?

_____ weeks

5. (REFER TO QUESTION 4a)

You indicated you spend a total of _____ hours per week in direct patient care and counseling. I would like to find out the different ways in which you spend your patient care time. I am particularly interested in how you divide it among five areas. Let me read them all first and then go over them one at a time. They are:

Face to face contact with patients in your own office or clinic.

On the telephone.

In a hospital emergency room, in its outpatient clinic or with its bed patients.

Now, to start again, how much time per week do you usually spend in

	Hours	or Percent	
(a) Face to face contact with patients in your own office or clinic?	____	____	
(PROBE) About how many minutes do you spend with each patient?			____ min.
(b) How much time per week on the telephone with patients?	____	____	
(PROBE) About how many minutes with each patient?			____ min.
(c) How much time per week in the hospital emergency room?	____	____	
(PROBE) About how many minutes with each patient?			____ min.
(d) How much time per week in a hospital outpatient department?	____	____	
(PROBE) About how many minutes with each patient?			____ min.
(e) How much time per week with your hospitalized patients?	____	____	
(PROBE) About how many minutes with each patient?			____ min.

(f) Are there any other places where you carry out or pursue patient care in a typical week?

( ) Yes ( ) No

(IF YES, ASK) What are they? (ASK, FOR EACH)
How much time is spent?

Place	Hours or Percent	
_____	____	____
_____	____	____
_____	____	____
_____	____	____

6. How many people work for you in your practice, including persons shared with other doctors?

Full time (35 hours or more per week) _____people

Part-time (less than 35 hours per week) _____people

7. (ASK ONLY OF SOLO PRACTITIONERS. DO NOT READ CHOICES, BUT RECORD PHYSICIAN'S ANSWER.)

What office facilities do you share with other doctors?

( ) None

( ) Reception room

( ) Examining rooms

( ) Consultation rooms

( ) Laboratory

( ) X-Ray

( ) Other, (please specify) _____

8. In a typical week, how many ambulatory patient contacts do you have, those seen in person and those contacted by telephone?

_____ patients per week

PATIENT FORM EVALUATION INTERVIEW SCHEDULE

03500

SAMC FORM EVALUATION INTERVIEW -

SURVEY OF AMBULATORY MEDICAL CARE

ED	
1 - 4	
5	
6 - 7	
8	
9	

FOR CODERS

DATE OF INTERVIEW: _____ INTERVIEWER'S NO: _____

CITY WHERE INTERVIEWED: _____

INTERVIEWER'S COMMENTS - RECORD ALL SIGNIFICANT OBSERVATIONS RELATING TO YOUR CONTACT WITH THIS DOCTOR:

_____

_____

_____

_____

_____

_____

RESPONDENT: _____
(Print Last Name First Name Initial)

_____
(Print Street Address)

_____
(Print City State Zip)

INTERVIEWER'S NAME: _____

Form Approved - Budget Bureau No. 68-S68099

SAMC FORM EVALUATION INTERVIEW

(To be administered to participating physicians after they have completed one quarterly assignment)

1. When were the patient record forms usually filled out? (Check one only)

   ( ) After each patient visit

   ( ) From time to time during the day, as time allowed

   ( ) All at once at end of each reporting day

   ( ) All at once at end of the reporting period

   ( ) Other _____

2. About how many minutes did it take to fill out each form? ____ min./form.

3. Who usually filled out the forms? _____

   Was anyone else involved? ( ) Yes ( ) No
   (IF YES) Who?

   _____

   What part did she (he, you) play in filling out the forms?

   _____

   _____

4. From what sources did you draw the information requested on the form? (DO NOT READ CHOICES, BUT RECORD PHYSICIAN'S ANSWER)

   ( ) Doctor's memory

   ( ) Nurse's or aide's memory

   ( ) Patient's medical record

   ( ) Bills/statements

   ( ) Other _____

5. Did you encounter any inconsistencies on the form?

( ) Yes ( ) No

(IF YES) What were they?

_____

_____

_____

6. Was there any information <u>not</u> requested in the patient record form which you think should be added for the sake of completeness?

( ) Yes ( ) No

(IF YES) What information?

_____

_____

7. What design or format changes can you suggest which you feel would make the form more useful or easier to fill out?

_____

_____

_____

(IF NONE) Then, you are generally satisfied with its layout as it stands?

( ) Yes

( ) No - Why not? _____

_____

8. Did you find that the use of the forms was helpful to you, in any way?

( ) Yes - How? _____

_____

( ) No

9. What did you do with your copies of the form? (DO NOT READ CHOICES, BUT RECORD PHYSICIAN'S ANSWER)

( ) Filed them in patient's record jackets

( ) Kept them all together in a file

( ) Sent them back

( ) Threw them away

( ) Other _____

10. Was your patient load during your reporting days unusual in any way with respect to number of patients, location of contacts, or time out of the office?

( ) Yes - In what way? _____

_____

( ) No

11. From what you know of this study, do you think that <u>other</u> physicians would participate in it?

( ) Yes

( ) No - Why not? _____

_____

12. With regard to the annual reporting schedule, would you prefer to report one day each month rather than two consecutive days each quarter?

( ) Yes ( ) No ( ) No preference

13. What would you suggest be done to increase the likelihood of participation by other physicians?

_____

_____

_____

(IF MONEY OR COMPENSATION IS MENTIONED, ASK) How much?

_____

(IF MONEY OR COMPENSATION IS NOT MENTIONED, ASK)

Would monetary compensation help?

( ) No

( ) Yes

(IF YES, ASK) How much? _____

14. There are some situations that a few physicians have been uncertain about including in this survey. Thinking back over the days during which you participated, do you recall seeing any patients who were ambulatory, perhaps at home or in an emergency room prior to hospitalization, that you did not report on?

( ) No

( ) Yes - Where did these contacts take place?

_____

_____

How many contacts were involved?

15. Do you keep any kind of daily list of patients contacted? ( ) Yes ( ) No

(IF YES) Does it include:	Yes	No	If no, proportion included
a. All office patients?	( )	( )	____
b. All telephone calls?	( )	( )	____
c. All hospital patients?	( )	( )	____
d. All emergency room patients?	( )	( )	____
e. All home visit patients?	( )	( )	____

Does it exclude any patients?

( ) No

( ) Yes, specify _____

_____

APPENDIX IV

DATA COLLECTION FORMS

FIELD TEST: PHASE II

SHORT FORM AND PATIENT LOG FOR NONSAMPLING PROCEDURE

PATIENT LOG

DATE ___ ___ 19___

As each patient arrives, record his name on the log below, and complete the correspondingly numbered patient record to the right.

PATIENT NUMBER	PATIENT'S NAME
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	

PHYSICIAN'S COPY

FORM A APPROVED - OMB NO. 00-67100
EXP. 6/30/71

NATIONAL AMBULATORY MEDICAL CARE SURVEY

PATIENT RECORD

PATIENT NUMBER 19150

DATE ___ ___ 19___
FOR CODING ONLY

① REASONS FOR THIS VISIT
Patient's purpose, problem or chief complaint

Most important diagnosis (definite or provisional)

Other diagnoses

② AGE
_____Yrs. or _____Mos.

③ SEX
1 ☐ Male
2 ☐ Female

④ COLOR OR RACE
1 ☐ White 3 ☐ Other
2 ☐ Negro 4 ☐ Unknown

⑤ CURRENT MARITAL STATUS
1 ☐ Never Married (include children)
2 ☐ Married 4 ☐ Separated or divorced
3 ☐ Widowed 9 ☐ Unknown

⑥ PATIENT SEEN BY YOU BEFORE?
1 ☐ Yes 2 ☐ No

IF YES, FOR THE PRESENT PROBLEM?
1 ☐ Yes 2 ☐ No

⑦ HISTORY
1 ☐ General
2 ☐ Limited
3 ☐ None

⑧ EXAMINATION
1 ☐ General
2 ☐ Limited
3 ☐ None

⑨ DIAGNOSTIC TESTS ORDERED THIS VISIT (check all that apply)

LABORATORY PROCEDURES	X-RAY EXAMINATIONS	OTHER DIAGNOSTIC PROCEDURES
1 ☐ Screening	1 ☐ Screening	1 ☐ Screening
2 ☐ Diagnostic	2 ☐ Diagnostic	2 ☐ Diagnostic
3 ☐ Follow-up	3 ☐ Follow-up	3 ☐ Follow-up
4 ☐ None	4 ☐ None	4 ☐ None

⑩ DIAGNOSTIC SPECIMEN TAKEN THIS VISIT BY
1 ☐ Physician
2 ☐ Staff
3 ☐ Other
4 ☐ None

⑪ TREATMENT THIS VISIT (check all that apply)
1 ☐ None required
2 ☐ Drug therapy
3 ☐ Office surgical treatment
4 ☐ Therapeutic injection and/or psychotherapy
5 ☐ Advised diet, exercise or habit changes
6 ☐ Family planning
7 ☐ Other (specify)_____

⑫ DISPOSITION THIS VISIT (check all that apply)
1 ☐ No further follow-up planned
2 ☐ Telephone follow-up planned
3 ☐ Return to me at anytime, p.r.n.
4 ☐ Return to me at specified time or interval
5 ☐ Referred for diagnostic work-up only
6 ☐ Referred to another physician for consultation, diagnosis or treatment
Referred for hospital admission
7 ☐ under my care
8 ☐ under another physician's care
9 ☐ Returned to referring physician or agency
X ☐ Other (specify) _____

⑬ DURATION OF THIS VISIT
_____Minutes

CONFIDENTIAL – All information which would permit identification of an individual or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey and will not be disclosed or released to other persons or used for any other purpose.

FORM A APPROVED - BUDGET BUREAU NO. 00-S70000
EXP. 6/31/71

FOR CODING ONLY ☐☐☐ ☐☐☐ ☐☐☐☐ ☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐ ☐☐☐ ☐☐

SHORT FORM WITH PATIENT LOG FOR SAMPLING PROCEDURE

NATIONAL AMBULATORY MEDICAL CARE SURVEY

26859 FOR CODING ONLY

PATIENT RECORD

26859

PATIENT LOG DATE ___ ___ 19__

As each patient arrives, record name, time of visit, age and sex on the log below. For the patient entered on line #3, also complete the patient record to the right.

	PATIENT'S NAME	TIME OF VISIT	AGE Yrs. or Mos.	SEX
1		a.m. / p.m.	Yrs. / Mos.	☐ M ☐ F
2		a.m. / p.m.	Yrs. / Mos.	☐ M ☐ F
3		a.m. / p.m.	Yrs. / Mos.	☐ M ☐ F

Record items ① – ⑫ for this patient

CONTINUE LISTING PATIENTS ON THE NEXT PAGE

CONFIDENTIAL – All information which would permit identification of an individual or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey and will not be disclosed or released to other persons or used for any other purpose.

① REASONS FOR THIS VISIT

Patient's purpose, problem or chief complaint

Most important diagnosis (definite or provisional)

Other diagnoses

② COLOR OR RACE
1 ☐ White
2 ☐ Negro
3 ☐ Other
4 ☐ Unknown

③ CURRENT MARITAL STATUS
1 ☐ Never married (include children)
2 ☐ Married
3 ☐ Widowed
4 ☐ Separated or divorced
5 ☐ Unknown

④ PATIENT SEEN BY YOU BEFORE?
1 ☐ Yes 2 ☐ No

IF YES, FOR THE PRESENT PROBLEM?
1 ☐ Yes 2 ☐ No

⑤ HISTORY
1 ☐ General
2 ☐ Limited
3 ☐ None

⑥ EXAMINATION
1 ☐ General
2 ☐ Limited
3 ☐ None

⑦ DIAGNOSTIC TESTS ORDERED THIS VISIT (check all that apply)

	LABORATORY PROCEDURES	X-RAY EXAMINATIONS	OTHER DIAGNOSTIC PROCEDURES
1 ☐	Screening	Screening	Screening
2 ☐	Diagnosis	Diagnosis	Diagnosis
3 ☐	Follow-up	Follow-up	Follow-up
4 ☐	None	None	None

⑧ DIAGNOSTIC SPECIMEN TAKEN THIS VISIT BY
1 ☐ Physician
2 ☐ Staff
3 ☐ Other
4 ☐ None

⑨ TREATMENT THIS VISIT (check all that apply)
1 ☐ None required
2 ☐ Drug therapy
3 ☐ Office surgical treatment
4 ☐ Therapeutic listening and/or psychotherapy
5 ☐ Advised diet, exercise or habit changes
6 ☐ Family planning
7 ☐ Other (specify) _____

⑩ DISPOSITION THIS VISIT (check all that apply)
1 ☐ No further follow-up planned
2 ☐ Telephone follow-up planned
3 ☐ Return to me at any time, p.r.n.
4 ☐ Return to me at specified time or interval
5 ☐ Referred for diagnostic tests only
6 ☐ Referred to another physician for consultation, diagnosis or treatment
7 ☐ Referred for hospital admission under my care
8 ☐ under another physician's care
9 ☐ Returned to referring physician or agency
X ☐ Other (specify) _____

⑪ DURATION OF THIS VISIT
_____ Minutes

FOR CODING ONLY

FORM C APPROVED: BUDGET BUREAU NO. 68-S70308 EXP. 6/31/71

MINIFORM AND PATIENT LOG FOR NONSAMPLING PROCEDURE

PATIENT LOG

DATE ____ ____ 19____

As each patient arrives, record his name on the log below, and complete the correspondingly numbered patient record to the right.

PATIENT NUMBER	PATIENT'S NAME
31	
32	
33	
34	
35	
36	
37	
38	
39	
40	

PHYSICIAN'S COPY

FORM G APPROVED - OMB NO. 68-871068
EXP. 9/30/71

NATIONAL AMBULATORY MEDICAL CARE SURVEY

PATIENT RECORD

AGE	SEX	DATE	PATIENT NUMBER
_____ Yrs. or _____ Mos.	1 ☐ Male 2 ☐ Female	DATE ____ ____ 19____	59801

DIAGNOSIS THIS VISIT

Most important diagnosis (definite or provisional)

_____

Other diagnoses

_____

_____

TREATMENT THIS VISIT (check all that apply)

1 ☐ None required
2 ☐ Drug therapy
3 ☐ Office surgical treatment
4 ☐ Therapeutic listening and/or psychotherapy
5 ☐ Advised diet, exercise or habit changes
6 ☐ Family planning
7 ☐ Other (specify)_____

_____

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FORM D APPROVED - BUDGET BUREAU NO. 68-870068
EXP. 6/31/71

MINIFORM WITH PATIENT LOG FOR SAMPLING PROCEDURE

85154

NATIONAL AMBULATORY MEDICAL CARE SURVEY

PATIENT RECORD

85154

PATIENT LOG

DATE ___ ___ 19___

As each patient arrives, record name, time of visit, age and sex on the log below. For the patient entered on line #3, also complete the patient record to the right.

	PATIENT'S NAME	TIME OF VISIT	AGE Yrs. or Mos.	SEX
1		a.m. / p.m.	Yrs. / Mos.	☐ M ☐ F
2		a.m. / p.m.	Yrs. / Mos.	☐ M ☐ F
3	Record diagnosis and treatment for this patient.	a.m. / p.m.	Yrs. / Mos.	☐ M ☐ F

CONTINUE LISTING PATIENTS ON THE NEXT PAGE

DIAGNOSIS THIS VISIT

Most important diagnosis (definite or provisional)

_____

Other diagnoses

_____

_____

TREATMENT THIS VISIT (check all that apply)

1 ☐ None required
2 ☐ Drug therapy
3 ☐ Office surgical treatment
4 ☐ Therapeutic listening and/or psychotherapy
5 ☐ Advised diet, exercise or habit change
6 ☐ Family planning
7 ☐ Other (specify) _____

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FORM P APPROVED - BUDGET BUREAU NO. 68-R70069
EXP. 8/31/71

MINIFORM WITHOUT PATIENT LOG FOR NONSAMPLING PROCEDURE

NATIONAL AMBULATORY MEDICAL CARE SURVEY

PATIENT RECORD

AGE	SEX		PATIENT NUMBER
_____ Yrs. or _____ Mos.	1 ☐ Male 2 ☐ Female	DATE — — 19 —	59798

DIAGNOSIS THIS VISIT

Most important diagnosis (definite or provisional)

_____

Other diagnoses

_____

_____

TREATMENT THIS VISIT (check all that apply)

1 ☐ None required
2 ☐ Drug therapy
3 ☐ Office surgical treatment
4 ☐ Therapeutic listening and/or psychotherapy
5 ☐ Advised diet, exercise or habit changes
6 ☐ Family planning
7 ☐ Other (specify)_____

_____

CONFIDENTIAL – All information which would permit identification of an individual or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey and will not be disclosed or released to other persons or used for any other purpose.

FORM D APPROVED - BUDGET BUREAU NO. 68-S70068
EXP. 8/31/71

ENLISTMENT INTERVIEW SCHEDULE

CONFIDENTIAL*

Form approved.
Budget Bureau No. 68-S70065
February 1971

NATIONAL OPINION RESEARCH CENTER
University of Chicago

Time Began:	AM / PM

NATIONAL AMBULATORY MEDICAL CARE SURVEY
Survey No. 4118

(Phys. ID Number)

INDUCTION INTERVIEW

As I said on the phone the other day, Dr. _____, I have a few questions to ask before we discuss the reporting procedures.

First, about your practice . . .

1. You are a _____. Is that right?
(ENTER SPECIALTY FROM CODE ON FACE SHEET LABEL.)

Yes 1
No . . . . . (ASK A) 2

A. IF NO: What is your specialty, (including general practice)?

_____
(Name of Specialty)

---

2. Do you practice solo, or are you associated with other physicians in a partnership, in a group practice, or in some other way?

Solo 1
Partnership (ASK A) 2
Group . . . (ASK A) 3
Other (SPECIFY AND ASK A) 4

_____

A. IF PARTNERSHIP, GROUP, OR OTHER: How many other physicians are associated with you?

_____
(# of Physicians)

---

*All information which would permit identification of an individual or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to other persons or used for any other purpose.

Now I'll take a few minutes to discuss with you the physician's role in the National Ambulatory Medical Care Survey. To understand this better, I should give you a little background about the origin of this survey.

There is a general lack of any systematic information about the characteristics and complaints of people who consult physicians in their offices. Such information is badly needed by medical educators and persons concerned with medical manpower needs.

In response to this need, NCHS (National Center for Health Statistics), in cooperation with representative of the medical profession has developed this survey of Ambulatory Medical Care. The information for this survey can be provided only by office-based physicians who provide care for ambulatory patients.

The task is simple, carefully designed, and should not take much of your time. Essentially it consists of your participation on two randomly selected consecutive days in each of four quarters. Your participation consists of filling out a minimal amount of information for each patient seen by you during that two-day period. Let me show you the form(s) involved now. TAKE OUT FOLIO AND SHOW FORM(S) TO THE DOCTOR.

EXPLAIN HOW FORMS ARE TO BE FILLED OUT. SHOW DOCTOR THE INSTRUCTIONS ON POCKET OF FOLIO TO WHICH HE CAN REFER AFTER YOU LEAVE.

RECORD VERBATIM ANY CONCERNS, PROBLEMS, OR QUESTIONS THE DOCTOR RAISES IN CONNECTION WITH THE EXPLANATION OF THE SURVEY OR THE COMMITMENT FOR FOUR QUARTERS.

Doctor, now that you know what the task is, let me tell you that your reporting days for this quarter are: READ DAYS OF WEEK AND DATES WHICH YOU CIRCLED FROM PAGE 3 OF CONTROL FOLDER.

M T W Th F Sa
and
M T W Th F Sa, March ____ and ____

---

3. Are you likely to see any ambulatory patients on those days?

Yes 1
No . . . (ASK A & B) . . . 2

IF NO:

A. Why is that?

3. Continued

IF NO TO 3:

B. Your alternate days would be (READ NEXT PAIR OF DAYS). Are you at all likely to see any ambulatory patients on those two days?

Yes 1

No . . . [ASK (1)] 2

(1) IF NO TO B: Would you please select any two consecutive days between March 8 and March 20 on which you would be likely to see any ambulatory patients?

Yes (RECORD SELECTED DAYS AND DATES IN BOX) 1

No (OFFER CHOICE OF ANY 2 DAYS BETWEEN MARCH 22 AND APRIL 2 AND RECORD SELECTED DAYS AND DATES IN BOX) 2

SELECTED REPORTING DAYS ARE:

M T W Th F Sa

and

M T W Th F Sa, March/April___ and ___

RECORD VERBATIM ANY COMMENTS DOCTOR MAKES WITH REFERENCE TO THE SELECTION OF REPORTING DAYS. IF REPORTING DAYS ARE UNACCEPTABLE FOR OTHER REASONS THAN ABOVE, RECORD VERBATIM HERE.

4. A. At which office location will you be seeing ambulatory patients during the 2-day reporting period? RECORD UNDER A BELOW AND ASK B WHEN INDICATED.

B. IF HOSPITAL EMERGENCY ROOM, OUT-PATIENT CLINIC, OR OTHER INSTITUTIONAL LOCATION IN A: Thinking about the ambulatory patients you see in (PLACE IN A), do you, yourself, have primary responsibility for their care over time, or does (INSTITUTION IN A) have primary responsibility for their care over time?

A. Office Location	B. Dr. has prime responsibility (in-scope)	B. Inst. has prime responsibility (out-of-scope)
(1) _____	1	0
(2) _____	1	0
(3) _____	1	0

5. During your 2-day reporting period (REPEAT EXACT DATES), will anyone be available to help in the survey reporting process (at each IN-SCOPE location)?

Yes . . . (ASK A) . . 1
No 2

A. IF YES: Who would that be? RECORD NAME, POSITION, AND LOCATION.			B. INTERVIEWER: WAS PERSON BRIEFED BY YOU?	
Name	Position	Location	Yes	No
			1	2
			1	2
			1	2
			1	2

Now I have just a few more questions about your practice during a typical week.

6. A. During a typical week, approximately how many hours do you spend each day caring for ambulatory patients? RECORD IN COLUMN A.

B. And about how many ambulatory patient visits do you have each day, during a typical week? RECORD IN COLUMN B.

Day of the week	A. Estimated hours	B. Estimated No. of patients
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

BEFORE YOU LEAVE, STRESS THAT EACH AMBULATORY PATIENT SEEN BY THE DOCTOR DURING THE 2-DAY PERIOD AT ALL IN-SCOPE LOCATIONS (REPEAT THEM) IS TO BE INCLUDED IN THE SURVEY.

Thank you for your time, Dr. _____. If you have any (more) questions, please feel free to call me. My phone number is written in on the folio. I'll call you the day before your reporting days just to remind you.

0			
Month		Date	

Time Ended: _____ AM PM

ITEMS I & II ARE TO BE COMPLETED BY THE INTERVIEWER AFTER THE INTERVIEW.

I. How much interest do you think the doctor has in the survey?

Great interest . . . 1
Some interest . . . 2
Little interest . . 3
No interest . . . 4
Can't tell 5

II. How confident are you that the doctor will complete the forms?

Definitely will . . . 1
Probably will 2
Doubtful 3

Interviewer #

Interviewer's Signature: _____

EVALUATION INTERVIEW SCHEDULE

CONFIDENTIAL*

NATIONAL OPINION RESEARCH CENTER
University of Chicago

Form approved.
Budget Bureau No.:
68-S?0065

NATIONAL AMBULATORY MEDICAL CARE SURVEY
Survey No. 4118

Feb. 1971

Time Began: _____ AM PM

SURVEY EVALUATION INTERVIEW

(Phys. ID Number)

Hello, Dr. _____. This is (YOUR NAME) from the National Opinion Research Center (of the University of Chicago). I called to thank you very much for your cooperation in the National Ambulatory Medical Care Survey. To complete your participation, I hope you will answer a few questions now to help us evaluate the survey.

NOTE: IF PROCEDURE V WAS USED BY THIS DOCTOR, BEGIN THIS INTERVIEW WITH Q. 2.

1. You will recall that two forms were used--the Patient Log and the Patient Record.

   A. First, tell me about the Patient Log--who, in your office, completed the Patient Log (for the most part)?

      Doctor himself 1
      Assistant who was briefed by interviewer . 2
      Someone else (SPECIFY) . . 3

   B. At what point were the patients' names (usually) entered on the log? DO NOT READ CATEGORIES.

      When patients checked in with receptionist or nurse 1
      When patients saw doctor 2
      Other (SPECIFY) 3

      _____

---

2. Now, tell me about the Patient Record. You may recall that there were two kinds of information requested on the Patient Record--personal and clinical.

   A. Who usually completed the items asking for clinical information?

      Doctor himself 1
      Assistant who was briefed by interviewer . 2
      Someone else (SPECIFY) . . 3

   B. Who usually completed the items asking for personal information?

      Doctor himself 1
      Assistant who was briefed by interviewer . 2
      Someone else (SPECIFY) . . 3

---

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2. Continued

C. Was anyone else involved in completing any part of the Patient Records?

Yes . [ASK (1) & (2)] . . . 1
No . (GO TO 3) 2

IF YES TO C:

(1) Who was that? _____
(Name) (Position)

(2) What part of the forms did (you/he/she/they) complete?

Clinical items 1
Personal items 2
Other (SPECIFY) 3

---

3. At what point in the process was the clinical information on the Patient Record filled out? DO NOT READ CATEGORIES

At the time patient saw doctor 1
At the end of each day (ASK A) 2
At the end of reporting period (ASK A) . 3
Other (SPECIFY AND ASK A) 4

A. IF NOT AT TIME PATIENT SAW DOCTOR: Was the clinical information entered mostly from memory, mostly from the patient's medical record, or mostly from something else?

Mostly memory 1
Mostly patient's medical record 2
Mostly something else (SPECIFY) 3

---

4. How long did it usually take to complete a Patient Record?

_____minutes
or
_____seconds

---

5. When filling out the Patient Records, were there any items or instructions that you had trouble with?

Yes . (ASK A) 1
No 2

A. IF YES: What were they?

ASK Q'S 6 AND 7 ONLY OF DOCTORS ASSIGNED PROCEDURES II OR IV; FOR OTHERS SKIP TO Q. 8.

6. Did you (OR PERSON) have any trouble filling out the Patient Log?

Yes . (ASK A) . . 1
No 2

A. IF YES: What was the trouble?

---

7. Did you (or the person filling out the forms) have any difficulty following the survey procedures because a Patient Record was completed for only every third patient?

Yes . (ASK A) . . 1
No 2

A. IF YES: What difficulties?

ASK EVERYONE:

8. We are trying to get some notion of how complete the information is which we have collected. We know that many things could have occurred to prevent you from keeping records on the two reporting days. How confident are you that the records you sent to us include every ambulatory patient seen by you during the 2-day reporting period--would you say you are confident that every patient was included, or that you got all except one or two, or that more than that were missed, for one reason or another?

Every patient was included . . . 1
Got all except one or two . . . 2
Missed more than that (ASK A) . 3
Can't recall 4

A. IF MISSED MORE THAN TWO: Why was that?

9. What changes do you suggest in order to make any of the forms more useful or easier to complete? RECORD IN APPROPRIATE COLUMN.

Patient Records	Patient Log

ASK Q. 10 ONLY IF "NO CHANGES" SUGGESTED IN Q. 9.

10. Are you generally satisfied with the forms as they are?

Yes 1
No . (ASK A) 2

A. IF NO: Why not?

11. With regard to the overall survey operation in your office, did you find that the procedures we asked you to follow were reasonable and easily adaptable to your office routine?

Yes 1
No . (ASK A) 2

A. IF NO: What changes in procedures do you suggest that would make your participation easier?

Now, about your practice.

12. Was your practice during the 2-day reporting period (GIVE DATES) unusual in any way?

Yes . . (ASK A-C) . 1
No 2

IF YES:

A. Was your patient load lighter than usual, heavier than usual, or about the same?

Lighter than usual . 1
Heavier than usual . 2
About the same . . . 3

B. How about the amount of time spent in caring for ambulatory patients--was that less than usual, more than usual, or about the same?

Less than usual . . 1
More than usual . . 2
About the same . . . 3

C. In what (other) ways was your practice unusual during your reporting period?

---

13. Doctor, we would like to get an idea of your total ambulatory patient load during the two-day reporting period, including telephone calls and patient contacts made outside of your office.

A. First, how many ambulatory patient contacts would you estimate took place by telephone during the two-day period--not including calls for appointments?

Number of patient contacts by telephone: _____

B. How many ambulatory patient contacts were not included in the survey because they took place outside of your office during the two-day period, such as in a hospital emergency room, in a patient's home, in an out-patient clinic, at the scene of an accident, or elsewhere?

Number of outside patient contacts: _____

---

14. What suggestions do you have for us to encourage participation in this survey by other physicians? (IF MONEY IS MENTIONED, PROBE FOR AMOUNT.)

15. A letter was sent to you by Mr. Theodore Woolsey of the National Center for Health Statistics (NCHS) urging you to participate. Did you receive that letter?

Yes . (ASK A) 1
No 2

A. IF YES: Did it influence your decision to participate?

Yes 1
No 2

---

16. There was also a letter from Dr. Howard, Executive Director of AMA urging you to take part in the study. Did you receive that letter?

Yes . (ASK A) 1
No 2

A. IF YES: Did it influence your decision to participate?

Yes 1
No 2

---

17. Did you happen to discuss the survey with anyone from your (local or) state medical society or one of your colleagues before you participated?

Yes, local or state medical society (ASK A) . . 1
Yes, colleague . . . . . (ASK A) . . 2
No, neither 3

A. IF YES: Did (that/those) discussion(s) influence your decision to participate?

Yes 1
No 2

---

18. Were there any (other) specific factors which influenced your decision to participate?

Yes . (ASK A) 1
No 2

A. IF YES: What were they?

19. We initially requested your participation in this survey during four quarterly 2-day periods. After having participated for the first period, how do you feel about participating during the other 2-day periods--would you definitely participate, probably participate, probably not participate, or definitely not participate?

Definitely would . . . 1
Probably would 2
Don't care one way or the other . 3
Probably would not (ASK A-D) . . 4
Definitely would not (ASK A-D) . 5
Don't know 6

IF PROBABLY NOT OR DEFINITELY NOT:

A. Why would you (probably) not participate?

B. (PROCEDURES I AND II ONLY): Would you be willing to participate if the Patient Record was different?

Yes 1
No 2

C. (PROCEDURES I, III, AND V): Would you be willing to participate if you were asked to complete only about ten Patient Records for each of the two days?

Yes 1
No 2

D. Are there any (other) conditions under which you would participate again?

Yes [ASK (1)] . . 1
No 2

(1) IF YES TO D: Under what conditions?

That's all the questions I have, Doctor. The information you have given us today will be most useful in evaluating our survey procedures. Thank you very much for all your help and cooperation.

FILL OUT ITEMS ON BACK COVER AFTER INTERVIEW.

Time Ended:	AM / PM

ITEMS BELOW ARE TO BE COMPLETED BY THE INTERVIEWER
AFTER THE INTERVIEW

1. How do you think the doctor feels about participating during the other three quarters?

Definitely would 1
Probably would 2
Probably would not 3
Definitely would not . . . 4
Can't tell 5

II. Was doctor cooperative during this evaluation interview?

Yes 1
No . . (ANSWER A) 2

A. IF NO: Why do you think he wasn't cooperative?

III. Was this interview conducted on the telephone? Yes 1
No (ANSWER A) . . 2

A. IF NO: Where was it conducted, and why were you not able to conduct it on the telephone?

Please record here any other comments or insights of your own which might help us in the evaluation of this survey.

Interviewer's Signature: _____ (Interviewer #) | | | | | |

Date of Interview: | 0 | | | | |
Month Date

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